

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07680

07662

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN TB 60 DAYS		d. STREET ADDRESS 907 N. Collington Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JERRY MARSHALL ALLEN		4. DATE OF DEATH Month Day Year JUNE 17 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 19 96
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DYE SETTER	
11. BIRTHPLACE (County & State, or foreign country) ALEXANDRIA, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD H. ALLEN		14. MOTHER'S MAIDEN NAME EMMA ALLISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 213 07 6074	
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADRENAL INSUFFICIENCY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from April 18 , 19 67 , to June 17 , 19 67 , that (we) last saw the deceased alive on June 17 , 19 67 , and that death occurred at 9:00PM from causes and on the date stated above.			
22a. SIGNATURE <i>Angela A. Topacto</i> ANGELA A. TOPACTO, M.D.		22b. DATE SIGNED 6/18/67	
22c. PHYSICIAN'S NAME (Type) ANGELA A. TOPACTO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Miller Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE JUN 19 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07684

CERTIFICATE OF DEATH

07683

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 5 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1431 E. Joppa Rd.		d. STREET ADDRESS 1431 E. Joppa Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Eleanor Allender		4. DATE OF DEATH Month Day Year June 19 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1904
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Koppers Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Thomas		14. MOTHER'S MAIDEN NAME Nellie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-9413	
17. INFORMANT Mr. Claude H. Allender		Address 1431 E. Joppa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Parkinson's Disease		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 1963, to June , 1967, that (I) (we) lost saw the deceased alive on 18 June 1967 , and that death occurred at 4:30 PM , from causes and on the date stated above.			
22a. SIGNATURE H. H. Bayliss		22b. DATE SIGNED 21 June 67	
22c. PHYSICIAN'S NAME (Type) H. H. BAYLISS		22d. ADDRESS 1600 WILKENS AVE	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/22/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.		25a. REC'D BY REGISTRAR DATE JUN 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the "body papers." Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reistertown c. LENGTH OF STAY IN IS 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bent Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS #302 Greenway, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANNA A. ANDERSON						4. DATE OF DEATH Month JUNE Day 19 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1907		9. AGE (in years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg.				11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Barnes						14. MOTHER'S MAIDEN NAME Rosa V. Whittington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. XXXXXXXXXX		17. INFORMANT Mr. Clarence W. Anderson (son) Address Same As #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis - chronic (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death: Minutes 7 years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month 19 Day 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-5-1967 to 6-19-1967 , that (I) (we) last saw the deceased alive on 6-18-1967 , and that death occurred at 6-19-1967 , from the causes and on the date stated above.											
22a. SIGNATURE Charles E. McWilliams M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 19, 1967			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Reistertown Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION (City, town or county) (State) Elkridge, RFD, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Singleton Funeral Home						25a. REC'D BY REGISTRAR Jan 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1988



Office of the Secretary

1. The first part of the report

is devoted to a description of the

work done during the year

and the results of the

investigation of the

problem of the

the results of the

investigation of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07683

CERTIFICATE OF DEATH

07665

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 1209 Delbert Avenue	
3. NAME OF DECEASED (Type or print) First John Middle T Last ANDRYSZAK		4. DATE OF DEATH Month June Day 10 Year 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1930
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Lithographing	9. AGE (In years last birthday) 36 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam A. Andryszak		14. MOTHER'S MAIDEN NAME Mary A. Grabowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1949-50		16. SOCIAL SECURITY NO. 212-28-6214	
17. INFORMANT Mrs. Frances C. Andryszak		Address 1209 Delbert Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Uremia DUE TO Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic nephritis (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial intestinal obstruction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 11, 1967 to June 10, 1967 , that (I) (we) last saw the deceased alive on June 10, 1967 , and that death occurred at 6:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Roberto Ferrer		22b. DATE SIGNED 6-10-67	
22c. PHYSICIAN'S NAME (Type) Roberto Ferrer		22d. ADDRESS 7620 York Road, Baltimore 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/14/67	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR M. F. Sadowski & Sons		25. REGISTRY BY REGISTRAR JUN 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

62034

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

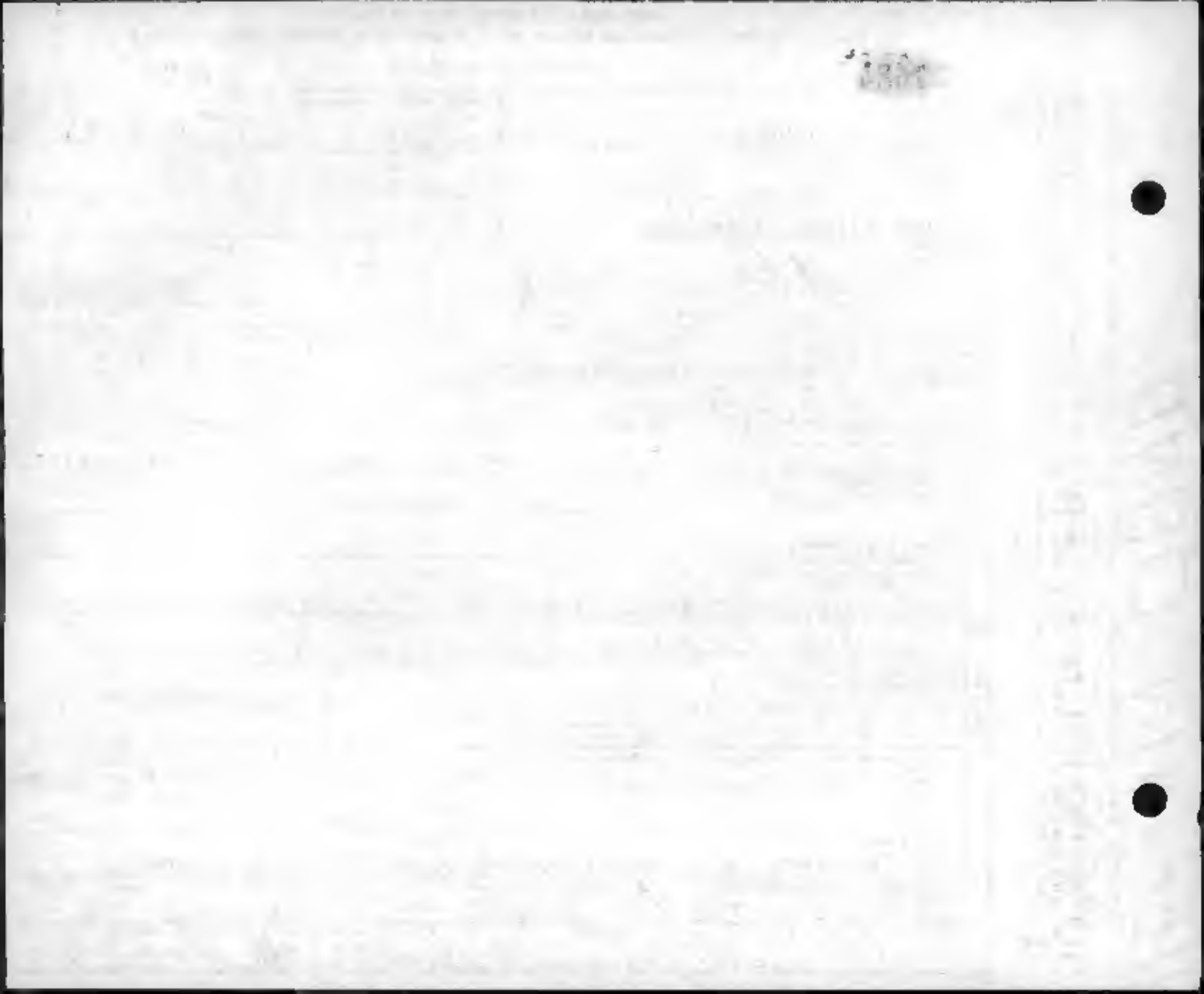
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07684

CERTIFICATE OF DEATH

07666

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY 7 CITY CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 48 MARKET PLACE	
3. NAME OF DECEASED (Type or print) First WEAD Middle MATTSON Last ARGABRIGHT		4. DATE OF DEATH Month JUNE Day 18 Year 1967	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/23
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Maintenance	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELMER ARGABRIGHT		14. MOTHER'S MAIDEN NAME BERTHA WEAD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 298-16-1463	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (b) 6 yrs DUE TO (c) 8 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC ALCOHOLISM			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-8 , 19 67 to 6-18 , 19 67 that (I) (we) last saw the deceased alive on 6-17 , 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 6-18-67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Buried June 23, 1967	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or town) (County) (State) BALTIMORE MD.
24. FUNERAL DIRECTOR Frank H. Howell		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 26 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event with the hospital or attending physician.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07685

CERTIFICATE OF DEATH

07667

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN <u>Towson</u>		2 USUAL RESIDENCE (When deceased lived in institution, residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN <u>Towson, Md. 21204</u>	
3 NAME OF DECEASED Type in print <u>Charles Lamar Armstrong</u>		4 DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <u>12-12-1911</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Rep. Warner Co.</u>		9b AGE in years Month <u>7</u> Day <u>10</u> Year <u>55</u>	
10 OTHER NAME <u>Joseph L. Armstrong</u>		11 MOTHER'S MAIDEN NAME <u>Rose Anderson</u>	
12 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		13 SOCIAL SECURITY NO. <u>064 07 7138</u>	
14 INTERVIEWER'S NAME <u>W.W.1</u>		15 INFORMANT <u>Mrs. Nora K. Armstrong, 1207 Culvert Rd.</u>	
16 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> CONDITIONS (if any) which gave rise to immediate cause (a). Shelling the underlying cause (b) <u>Intermittent</u> (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a AFFIDENTIAL UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER THAN MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8.)	20c PLACE OF INJURY Home, farm, factory, street, office bldg., etc.	
20d TIME OF INJURY Month Day Year Hour a.m. p.m.	20e INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f (City or town)	20g (County) (State)
21 I certify that this hospital attended the deceased from <u>June 18, 1967</u> to <u>June 22, 1967</u> that I have last seen the deceased alive on <u>June 22, 1967</u> and that death occurred at <u>6:30</u> M. from causes and on the date stated above			
22a SIGNATURE <u>George T. Gilmore</u>	22b ADDRESS <u>1717 York Road, Towson, Maryland</u>	22c DATE SIGNED <u>June 23, 1967</u>	
23a BURIAL (CREMATION) REMOVAL (EMBALM)	23b DATE THEREOF <u>6-26-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Balto., Md.</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Md.</u>	25a REC'D BY REGISTRAR <u>REC'D 2.6.1967</u>	25b REGISTRAR'S SIGNATURE <u>Thos. Judge</u>	

VR AIS
20 M 1/8



Charles Judge

WR AES 41
20 APR '65



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

07687

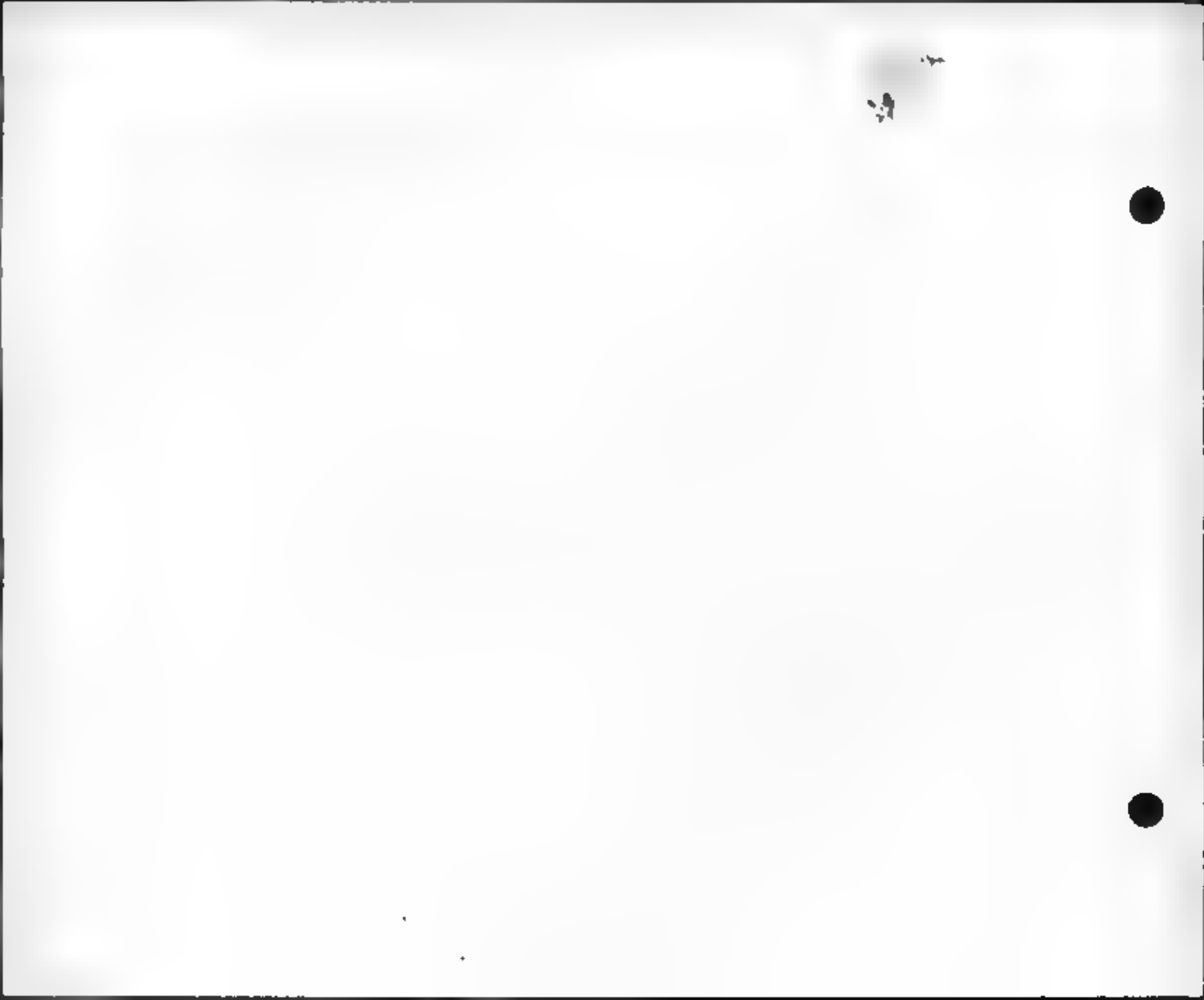
CERTIFICATE OF DEATH

07669

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN b 21 34	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		e STREET ADDRESS 3016 Woodhome Ave.	
3 NAME OF DECEASED First Middle Last Giovannino D. Barrasso		4 DATE OF DEATH Month Day Year June 26 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-24-97
9 AGE (In years last birthday) 70		10 UNDER YEAR Months Days Hours Min 24 00 00 00	
11a Usual OCCUPATION (Give kind of work done during most of working life even if retired) Merchant Marine		11b KIND OF BUSINESS OR INDUSTRY Italy	
12 FATHER'S NAME Anthony Barrasso		13 MOTHER, MAIDEN NAME Maria S. Rugiero	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		15 SOCIAL SECURITY NO 213 07 5827	
16 CAUSE OF DEATH (Enter only one cause per line or a, b, and c) PART I IMMEDIATE CAUSE Acute myocardial infarction (anterior)		17 INTRACRANIAL OR WITH INTRACRANIAL DEATH	
18 CONDITIONS (If only which gave rise to immediate cause or stating the underlying cause) a DUE TO Thrombosis of the left coronary artery b DUE TO Atherosclerosis - generalized - severe c		19	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Diabetes Mellitus			
20a A. WHEN WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? b. HER NO. IF MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item B.)	
20c TIME OF INJURY Month Day Year June 26 19 67		20d PLACE OF INJURY Home room Factory street office bldg. el. Home room	
20e PLACE OF INJURY Home room Factory street office bldg. el. Home room		20f PLACE OF INJURY Home room Factory street office bldg. el. Home room	
21 I certify that (a) (this hospital) attended the deceased from June 12 19 67 to June 26 19 67 that (b) we first saw the deceased alive on June 26 19 67 and that death occurred at 5:20 PM from causes and on the date stated above			
22a SIGNATURE Manual Cockburn M.D.		22b DATE 6-27-67	
22c PHYSICIAN'S NAME Type Manual Cockburn, M.D.		22d ADDRESS 7623 York Rd. Baltimore, Md. 1204	
23a BURIAL OR CREMATION Buried	23b DATE HEREOF 6/30/67	23c NAME OF MAFRY OR CREMATORY Gardens of Faith Cem.	23d LOCATION City or town Baltimore, Maryland
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. Balto. 11		25a REC'D BY REGISTRAR 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be attached to this certificate. Then please return to the State Department of Health. Page 2 should be filed with the State Department of Health prior to being a strength or removal and may even be filed with the State Department of Health.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07688
CERTIFICATE OF DEATH
07610

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Balto.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med Cen</u>		d. STREET ADDRESS <u>3808 Eastwood Drive #6</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Jackson Barton</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/23</u>
9. AGE (in years, last birthday) <u>43</u> yrs		10. FUNDING YEAR <u>1965</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professional Officer Edgewood Branch Balto. Md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Barton</u>	
14. MOTHER'S MAIDEN NAME <u>Betty Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>yes WWII</u>	
16. SOCIAL SECURITY NO. <u>21-12-8808</u>		17. INFORMANT <u>Amelia Barton (nee Oleska), above, wife</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DOE TO</u> (c) <u>DOE TO</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHERS ON F. CANT. CONDITIONS CONTR. BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUT NOT CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> b.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-12-1967</u> to <u>6-17-1967</u> , that (I) (we, last saw the deceased) <u>6-17-1967</u> , and that death occurred at <u>5 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>In Adelaide Marie Gough</u> M.D.		22b. DATE SIGNED <u>6-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAM. MCARDIST</u>		22d. ADDRESS <u>for Baltimore Medical Center</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	23d. LOCATION (City town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u>		25. REC'D BY REG. STAR <u>JUN 20 1967</u>	
25a. ADDRESS <u>3331 Brehms Lane #13</u>		25b. REG. STAR'S SIGNATURE <u>[Signature]</u>	



VR A SMF 75
SM 66

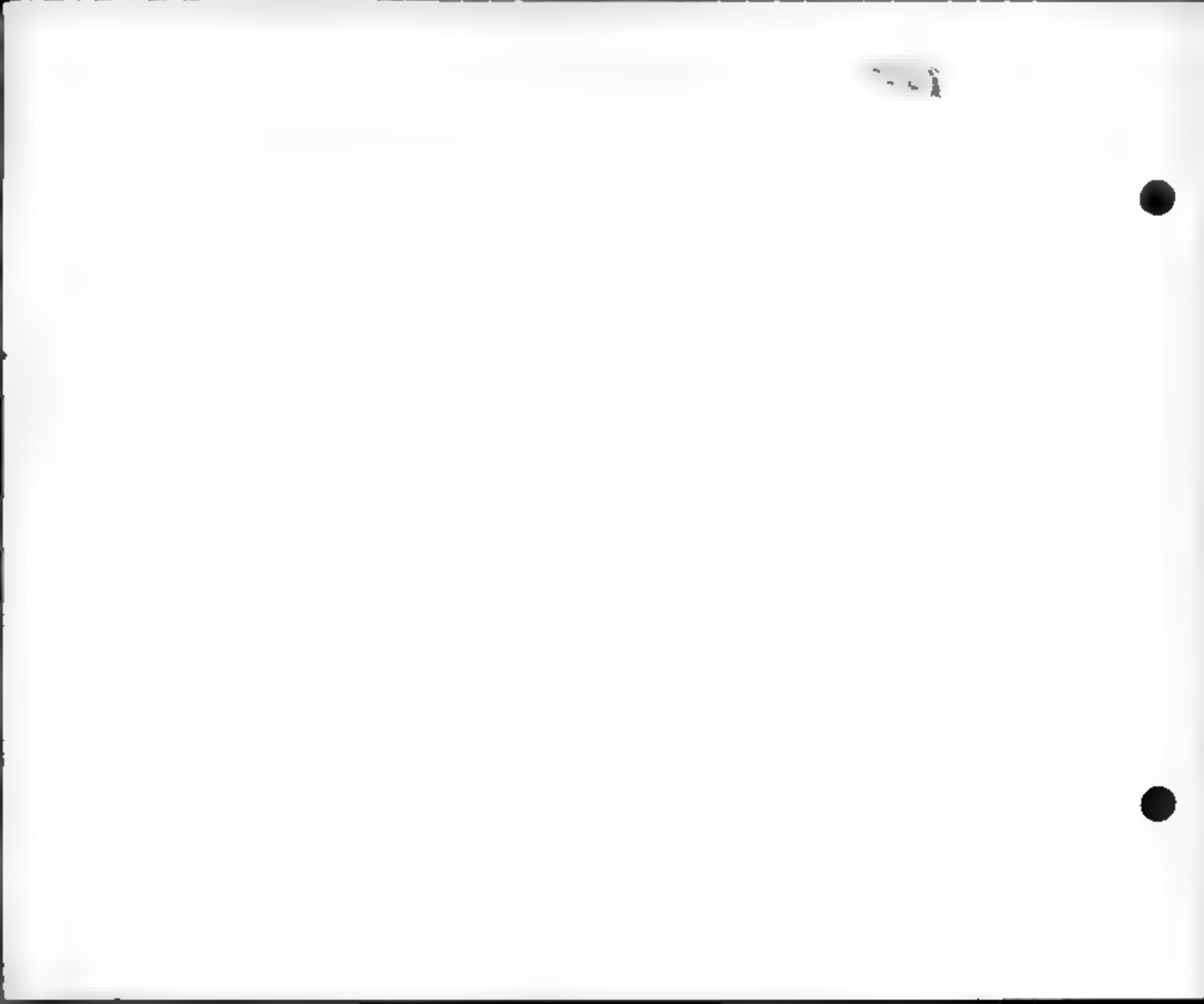
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07689

07671

1 PLACE OF BIRTH a. <u>BALTO.</u>		USUAL RESIDENCE b. STATE <u>MD</u>	
b. CITY OR TOWN (in outside corporate limits write R.R. No. and name of town) <u>TOWSON</u>		c. COUNTY <u>BALTO.</u>	
d. NAME OF HOSPITAL OR OTHER PLACE OF DEATH <u>ST JOSEPH HOSP</u>		e. NAME OF TOWN OR PLACE OF DEATH <u>PARKTON</u>	
f. NAME OF DECEASED <u>RICHARD H. BAUBLITZ</u>		g. DATE OF DEATH <u>JUNE 25 1967</u>	
h. MARRIAGE i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		j. BIRTH <u>OCT 17 1924</u>	
k. OCCUPATION <u>FOREMAN</u>		l. PLACE OF BIRTH <u>U.S.A.</u>	
m. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		n. NAME OF DECEASED <u>MARY E. TILLMAN</u>	
o. WAS DECEASED OVER IN U.S. ARMY OR NAVY <u>NO</u>		p. NAME OF DECEASED <u>RUTH X BAUBLITZ</u>	
q. CAUSE OF DEATH (Enter only one cause per line for (a) through (d)) PAR DEATH WAS CAUSED BY <u>MYOCARDIAL INFARCTION</u>		r. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
s. OTHER SIGNIFICANT CONDITIONS <u>NO</u>		t. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
u. INTERNAL CAUSE PRIMARY OR CONTRIBUTING CAUSE OF DEATH <u>NO</u>		v. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
w. IM OF INJURY a. IM OF INJURY b. IM OF INJURY c. IM OF INJURY d. IM OF INJURY		x. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
y. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		z. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
aa. ACTUAL SIGNATURE <u>William A. Pillsbury</u>		bb. DATE SIGNED <u>6-25-67</u>	
cc. EXAMINER'S NAME (Type) <u>William A. Pillsbury</u>		dd. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
ee. BIRTH <u>1924</u>		ff. DATE HEREOF <u>JUNE 28 1967</u>	
gg. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		hh. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
ii. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		jj. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
kk. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		ll. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
mm. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		nn. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
oo. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		pp. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
qq. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		rr. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
ss. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		tt. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
uu. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		vv. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
ww. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		xx. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	
yy. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>		zz. NAME OF DECEASED <u>JOSEPH H. BAUBLITZ</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

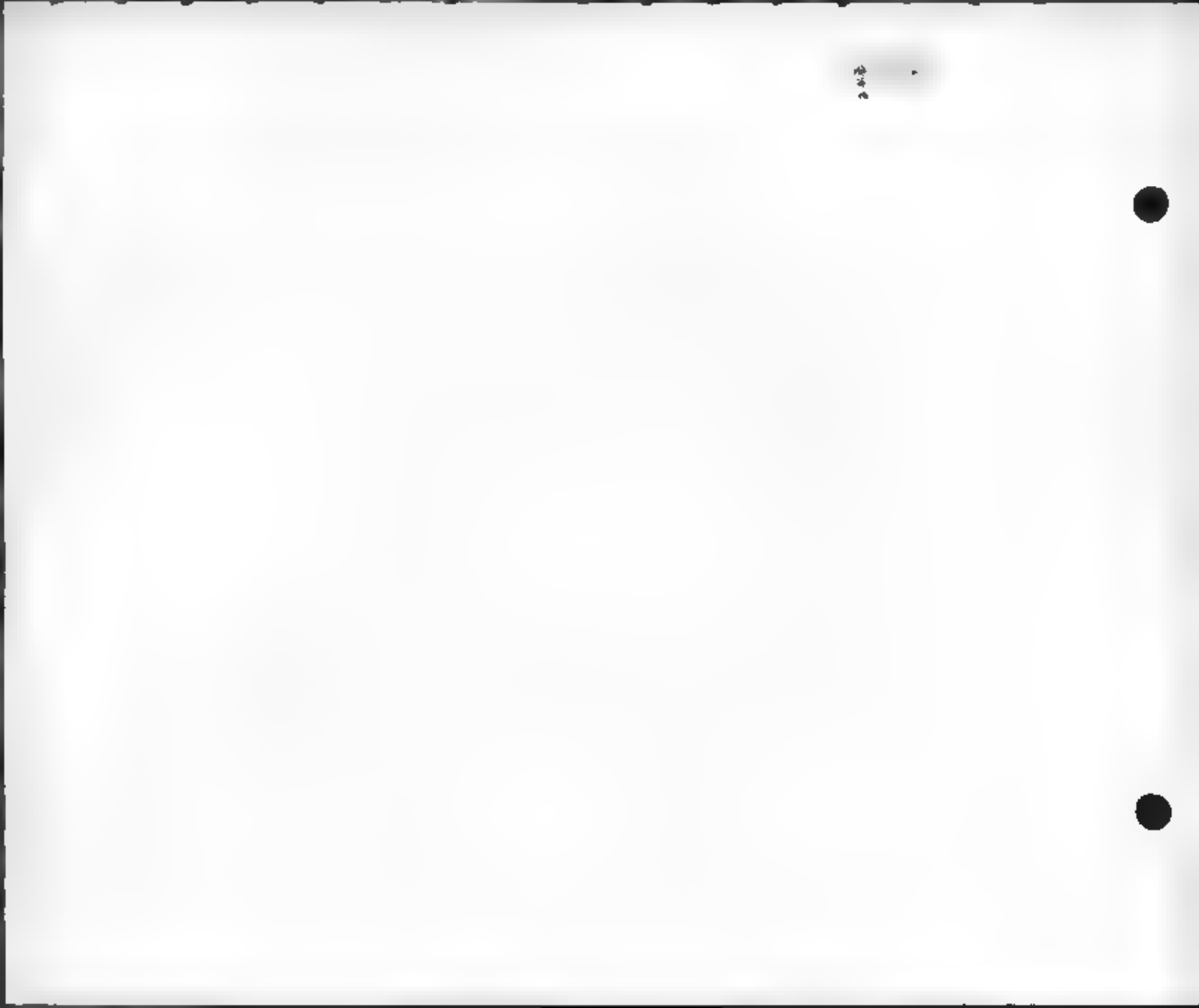
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07691

07673

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 Fore x-41</u>		d. STREET ADDRESS <u>1 Fore x-41</u>	
4. NAME OF DECEASED (Type or print) <u>Elizabeth May Berry</u>		5. DATE OF DEATH <u>June 7 1967</u>	
6. SEX <u>F</u>		7. DATE OF BIRTH <u>May 7 1907</u>	
8. COLOR OR RACE <u>W</u>		9. AGE (in years last birthday) <u>60</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Insurance</u>	
11. FATHER'S NAME <u>James Thomas</u>		12. MOTHER'S MAIDEN NAME <u>Elizabeth G. Thomas</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <u>No</u>		14. SOCIAL SECURITY NO. <u>5-14-5744</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Pancreatitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Ulcerative Colitis</u>		PART 2 OTHERS, IF ANY, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2 of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>June 7 1967</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7 1967</u> that (I) (we), as saw the deceased alive on <u>June 7 1967</u> , and that death occurred at <u>8:48 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE OF PHYSICIAN <u>William A. Tyson</u>	
22b. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		22c. ADDRESS <u>Kingsville, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		23d. LOCATION (City town or county) (State) <u>Belair</u>	
24. FUNERAL DIRECTOR <u>John C. Wilson Inc.</u>		24b. ADDRESS <u>4111 E. Pratt St. - 1111</u>	
25a. REC'D BY REG. STRAIP <u>Charles Judge</u>		25b. REG. STRAIP'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 12 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation or removal.

VR 115 (4)
20M 5/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07692

CERTIFICATE OF DEATH

27673

1. PLACE OF DEATH
a. COUNTY Baltimore

2. USUAL RESIDENCE (Where deceased lived, -1 institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville

c. LENGTH OF STAY IN 1b
app 27 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Paradise Nursing Home

d. STREET ADDRESS
103 Oakdale Ave.

3. NAME OF DECEASED (Type or print)
First FRANK Middle F. Last BIEMILLER

4. DATE OF DEATH
Month JUNE Day 22 Year 1967

5. SEX male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ DIVORCED ☐

8. DATE OF BIRTH
Month June Day 26 Year 1883

9. AGE (In years last birthday)
83 Months 7 Days 23 Hours 19 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Telephone Co.

10b. KIND OF BUSINESS OR INDUSTRY
C&P Tel Co.

11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME
John H. Biemiller

14. MOTHER'S MAIDEN NAME
Caroline Preß

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No, or Unknown: no

16. SOCIAL SECURITY NO.
212-05-0617

17. INFORMANT
John A. Biemiller Address 200 Devonshire Rd.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
Gangrene left foot
DUE TO Arterio-sclerotic peripheral Vascular Disease
DUE TO Chronic Brain Syndrome
DUE TO Arterio-sclerotic
DUE TO Chronic Brain Syndrome
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome
INTERVAL BETWEEN ONSET AND DEATH
8 weeks
1 yr +
5 yrs +
(2 yrs)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS IMPOSSIBLE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
2/19/65

20c. TIME OF INJURY Month, Day, Year
Hour 19 M. P.M.

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)
6/22/67

20f. (City or town) (County) (State)

21. I certify that (this hospital attended the deceased from 6/21/67 to 6/22/67), that (1) I last saw the deceased alive on 6/21/67, and that death occurred 9:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE
W.E. McGrath

22b. DATE SIGNED
6/23/67

22c. PHYSICIAN'S NAME (Type)
W.E. McGrath MD

22d. ADDRESS
1303 Frederick Rd Catonsville Md

22e. MED. DIRECTOR ☐ STAFF PHYS. ☐

23a. DISPOSITION OF REMAINS (Specify)
Burial

23b. DATE THEREOF
June 26, 1967

23c. NAME OF CEMETERY OR CREMATORY
Landon Park Cem.

23d. LOCATION (City, town or county) (State)
Baltimore, Md.

24. FUNERAL DIRECTOR
STERLING F. NEAL ESTATE

25a. REC'D BY REGISTRAR
27 1967

25b. REGISTRAR'S SIGNATURE
Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER:

neatory please see the e-lic to w ing the word penning in pencil in em 18 Give Pages 1 2 and 3 the nro d p a Page 4 s id to forwarded to the Chet Med cal Examiners Office along with form PM3 Page 5 mty be a p d + 10. Bx

TO FUNERAL DIRECTOR Page 3 d could be set as o b b n g h n s i f e m f e p o g e s 1 and 2 w n the State Department of Health prior to burial, cremation or entombment and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

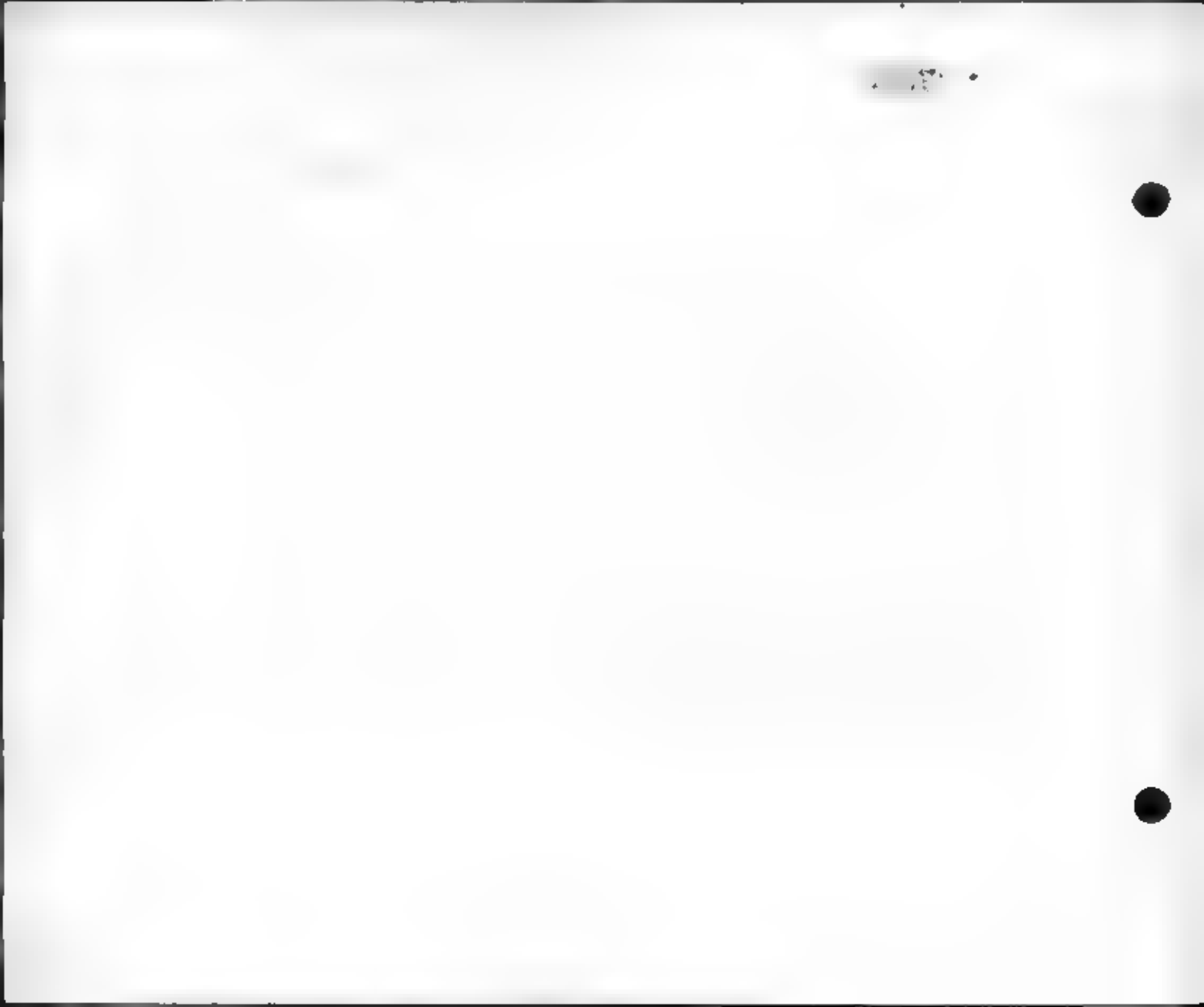
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07693

07675

PLACE OF BIRTH a. COUNTY Baltimore b. CITY OR TOWN Towson		USUAL RESIDENCE WHEN DECEASED a. COUNTY Maryland b. CITY OR TOWN Harford	
c. RACE White		d. SEX Male	
e. DATE OF DEATH June 5, 1967		f. TIME OF DEATH 2 hrs.	
g. NAME OF HOSPITAL OR PLACE OF DEATH St Joseph's Hospital		h. ADDRESS XXXXXX Nelson Mill Road	
i. NAME OF DECEASED First Middle Last CHARLES James BILLINGS		j. DATE OF BIRTH 2/12/1921	
k. MARRIAGE STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		l. AGE 46	
m. OCCUPATION Laborer		n. PLACE OF BIRTH Trout Dale, Virginia	
o. FATHER'S NAME Whittmore Billings		p. MOTHER'S NAME Nannie Billings	
q. ADDRESS No. 232-24-8657		r. ADDRESS RD #2 Box 103A	
s. CAUSE OF DEATH PART 1: Massive Internal Bleeding PART 2: gunshot wound of abdomen and chest involving the liver and lung.		t. PLACE OF DEATH Forrest Hill, Harford, Md.	
u. TIME OF DEATH 4:30		v. DATE OF DEATH 6/5/1967	
w. TIME OF DEATH Home		x. PLACE OF DEATH Forrest Hill, Harford, Md.	
y. I certify that the above information is true and correct to the best of my knowledge and belief. Werner U. Spitz, M.D.		z. DATE SIGNED 6/6/67	
aa. SIGNATURE OF DECEASED Burial		bb. SIGNATURE OF DECEASED Sharon Baptist	
cc. SIGNATURE OF DECEASED Charles E. Kurtz		dd. SIGNATURE OF DECEASED Jarrettsville, Md.	
ee. SIGNATURE OF DECEASED 21084		ff. SIGNATURE OF DECEASED Forest Hill, Maryland	
gg. SIGNATURE OF DECEASED Charles E. Kurtz		hh. SIGNATURE OF DECEASED 21084	

VER A SAME (5)
6/6/67



CERTIFICATE OF DEATH

07694

07678

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE Where deceased lived if institution Reidence before admission a STATE MARYLAND b COUNTY CARROLL	
b CITY OR TOWN If inside corporate limits write RURAL and give nearest town RANDALLSTOWN		c LENGTH OF STAY IN b 3 DAYS	
d NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address BALTIMORE COUNTY GENERAL		e STREET ADDRESS 503 1/2 3rd Arthur Ave	
3 NAME OF DECEASED Type in print George Edward Blatchley		4 DATE OF DEATH Month 6 - Day 9 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept 10, 1907
9 AGE In years 10 - 11 - 12 - 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20 - 21 - 22 - 23 - 24 - 25 - 26 - 27 - 28 - 29 - 30 - 31 - 32 - 33 - 34 - 35 - 36 - 37 - 38 - 39 - 40 - 41 - 42 - 43 - 44 - 45 - 46 - 47 - 48 - 49 - 50 - 51 - 52 - 53 - 54 - 55 - 56 - 57 - 58 - 59 - 60 - 61 - 62 - 63 - 64 - 65 - 66 - 67 - 68 - 69 - 70 - 71 - 72 - 73 - 74 - 75 - 76 - 77 - 78 - 79 - 80 - 81 - 82 - 83 - 84 - 85 - 86 - 87 - 88 - 89 - 90 - 91 - 92 - 93 - 94 - 95 - 96 - 97 - 98 - 99 - 100 59		9 AGE In years 10 - 11 - 12 - 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20 - 21 - 22 - 23 - 24 - 25 - 26 - 27 - 28 - 29 - 30 - 31 - 32 - 33 - 34 - 35 - 36 - 37 - 38 - 39 - 40 - 41 - 42 - 43 - 44 - 45 - 46 - 47 - 48 - 49 - 50 - 51 - 52 - 53 - 54 - 55 - 56 - 57 - 58 - 59 - 60 - 61 - 62 - 63 - 64 - 65 - 66 - 67 - 68 - 69 - 70 - 71 - 72 - 73 - 74 - 75 - 76 - 77 - 78 - 79 - 80 - 81 - 82 - 83 - 84 - 85 - 86 - 87 - 88 - 89 - 90 - 91 - 92 - 93 - 94 - 95 - 96 - 97 - 98 - 99 - 100 59	
10a USUAL OCCUPATION Give kind of work done during year of preceding life even if retired FOREMAN		10b KIND OF BUSINESS OR INDUSTRY Leo J McCourt	
11 FATHER'S NAME ROBERT H BLATCHLEY		12 MOTHER'S MAIDEN NAME SUSAN BARNES	
13 WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no or unknown) (If yes give war or dates of service) No		14 SOCIAL SECURITY NO 100-1-100000	
15 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arterio-sclerotic heart failure DUE TO (c) Pulmonary embolism		16 INTRAVENOUS RE-VEIN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II at item 18	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 9	20d INJURY OCCURRED While at work <input type="checkbox"/> No While at work <input type="checkbox"/>	20e PLACE OF INJURY Home farm factory, street, office bldg, etc.	20f City or town County State
21 I certify that (a) (this hospital attended the deceased from 6-6 , 19 67 to 6-9 , 19 67 that) we last saw the deceased alive on 6-9 , 19 67 and that death occurred at 10:15 M. from causes and on the date stated above			
22a SIGNATURE DR LAI		22b DATE SIGNED 6/9/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL OR CREMATION Specify	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORIUM	23d LOCATION (City or Town County State)
BURIAL	JUNE 12, 1967	PARKWOOD Cemetery	Parkville Baltimore Md
24 FUNERAL DIRECTOR Wm Cook-Brook Tauson		25a REGISTRATION JUN 14 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director page 3 should be detached for use as the burial "transfer" permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial. cremation or removal of the body. A copy of the death certificate should be filed with the State Dept of Health prior to burial. cremation or removal of the body.

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

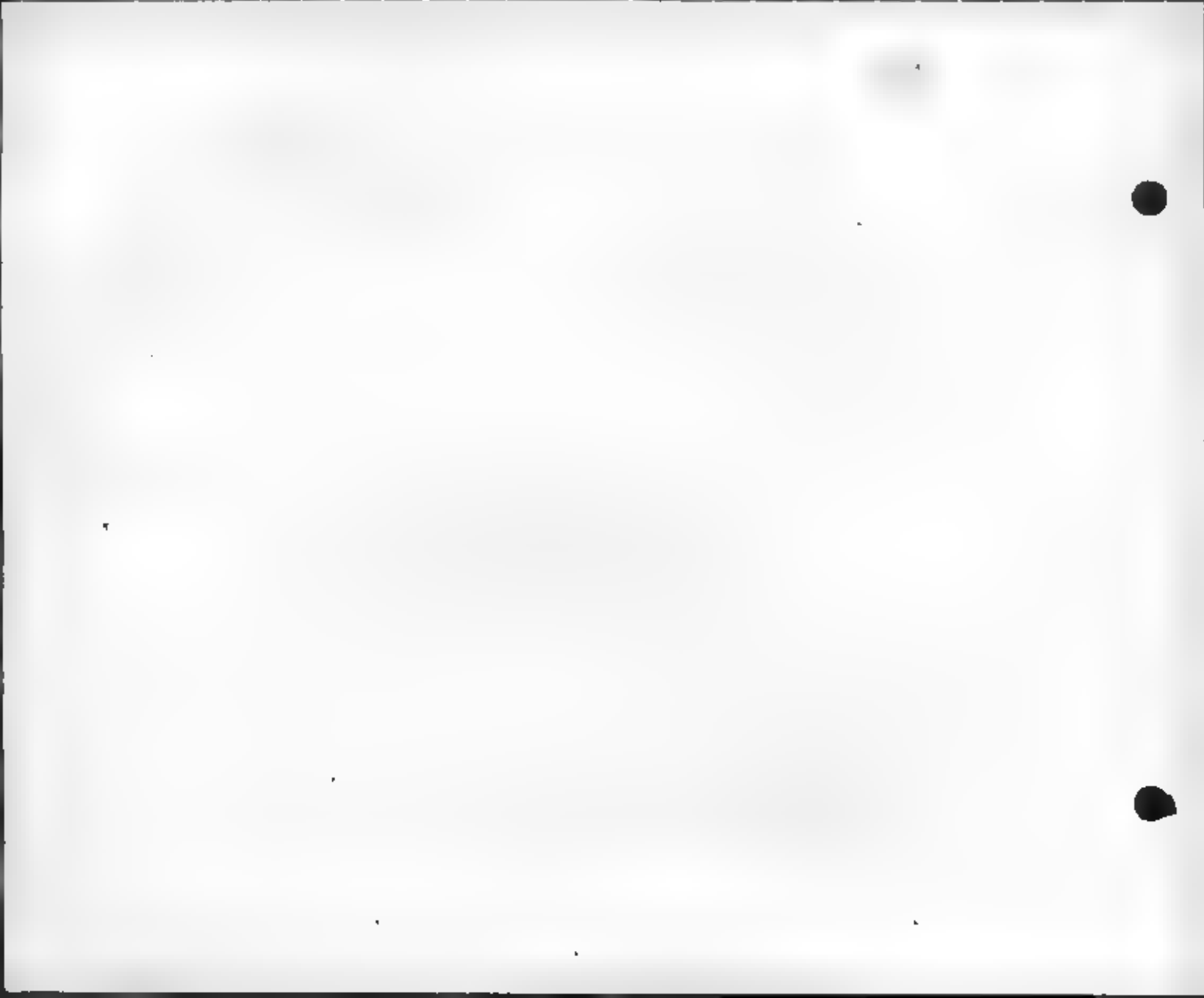
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07693

CERTIFICATE OF DEATH

07677

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN b 30 yr d. NAME OF HOSPITAL, OR INS'TITUTION (If not in hospital, give street address) ST JOSEPH HOSPITAL		2. USUAL RESIDENCE (Where deceased lived if in institution. Resident & home address if in STATE MARYLAND COUNTY BALTIMORE CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE d. STREET ADDRESS OSLER DRIVE, TOWSON. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First ELMER Middle MARTIN Last BLISS Type of print		4. DATE OF DEATH Month 6 Day 30 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8 1881 9. AGE (In years (as birthday) 86 yrs 10. UNDER 24 HRS Month 1 Day 30 Hours 15 Min.
11. OCCUPATION (Give kind of work done during last year, working life even if retired) HOTEL CLERK.		12. KIND OF BUSINESS OR INDUSTRY HOTEL	
13. FATHER'S NAME MARTIN BLISS		14. MOTHER'S MAIDEN NAME LIBBY MONROE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 216-65 0835	
17. INFORMANT J E MOYLEAN Address 807 MORRIS P.C. LUTHERVILLE, MD		18. INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 days		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO	
21. 1 certify that (1) (this hospital) attended the deceased from 1963 to 6-30-1967 , that (1) (we) last saw the deceased alive on 6-30-1967 , and that death occurred at 11:00 PM , from causes and on the date stated above.		22. SIGNATURE Keith A. Manley M.D. 22a. PHYSICIAN'S NAME (Type) KEITH A. MANLEY	
23a. BIRTHAL (CRIMINATION, REMOVAL, SPECIFY) 11-11		23b. DATE THEREOF 7/3/67	
23c. NAME OF CEMETERY OR CRIMATORY Dulaney Valley Mem.		23d. LOCATION (City or town) (County) (State) Balto. Co.	
24. FUNERAL DIRECTOR Nitchell-Wiegand Address 6 York Road 21212		25a. REC'D BY REGISTRAR JUL 5 1967 25b. REGISTRAR'S SIGNATURE James J. Age	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, page 4 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

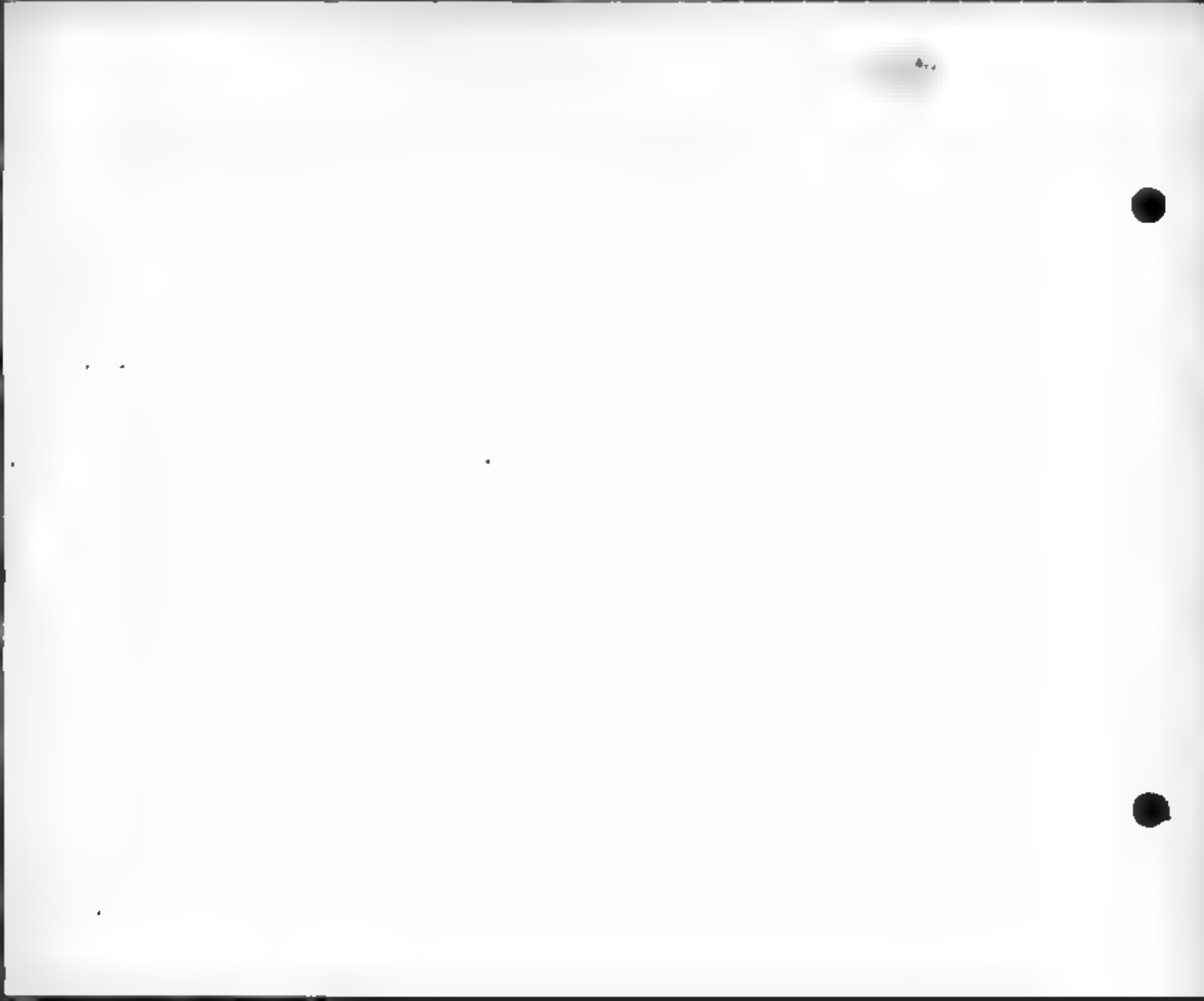
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201

07696

CERTIFICATE OF DEATH

07678

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (include corporate limits, write R.R. and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21213	
3 NAME OF DECEASED (Type in print) Joseph Michael Bolewicki, Sr.		4 DATE OF DEATH Month June Day 23 Year 1967	
5 SEX Male		6 COLOR OR RACE White	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH January 13, 1898	
9 AGE in years, months, days 69		10 UNDER 23 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/>	
11 INDUSTRY OR OCCUPATION (Give kind of work done during last 12 months, or working life, even if retired) Self-Employed Retired		12 KIND OF BUSINESS OR SERVICE Appliance Dealer	
13 BIRTHPLACE (County & State or foreign country) Maryland		14 U. S. A. <input type="checkbox"/> OTHER COUNTRY <input type="checkbox"/>	
15 FATHER'S NAME Joseph Bolewicki		16 MOTHER'S MAIDEN NAME Anna Lubinski	
17 DECEASED EVER IN ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		18 SOCIAL SECURITY NO. 216-32-4259	
19 INFORMANT (Name) Mrs. Lillian Bolewicki		20 ADDRESS Baltimore Md. 21213	
21 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) a. IMMEDIATE CAUSE (b) Arteriosclerotic heart disease in congestive heart failure c. heart failure		22 INFER A DISTINCTION BETWEEN ONSET AND DEATH	
23 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Cerebrovascular thrombosis		24 INFER A DISTINCTION BETWEEN ONSET AND DEATH	
25a. WHEN DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 25b. TIME OF INJURY (Month, Day, Year) Hour a.m. 19 o.m. 19		26 DESCRIBE HOW INJURY OCCURRED (Fatal nature of injury in Part I or Part II of item B) 26a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
27a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27b. (City or town) (County) (State)	
28 I certify that (X) this hospital attended the deceased from June 17, 1967 to June 23, 1967 that (X) we last saw the deceased alive on June 23, 1967 and that death occurred at 12:15 PM from causes and on the date stated above		29 SIGNATURE Ramon P. Lopez 29a. PHYSICIAN'S NAME Type Ramon P. Lopez, M.D.	
30 ATTENDING PHYSICIAN M.D. <input type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		31 DATE SIGNED June 23, 1967	
32 ADDRESS 7620 York Rd., Towson, Md. 21204		33 DATE June 23, 1967	
34 BURIAL OR CREMATION Burial		35 DATE THEREOF 6/27/67	
36 NAME OF THE TOWN OR CEMETERY St. Stanislaus Cemetery		37 LOCATION (City or town) (County) (State) Baltimore, Md.	
38 FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.		39 RECORD BY REGISTRAR DATE JUN 27 1967	
40 REGISTRAR'S SIGNATURE Charles Judge		41 REGISTRAR'S SIGNATURE Charles Judge	



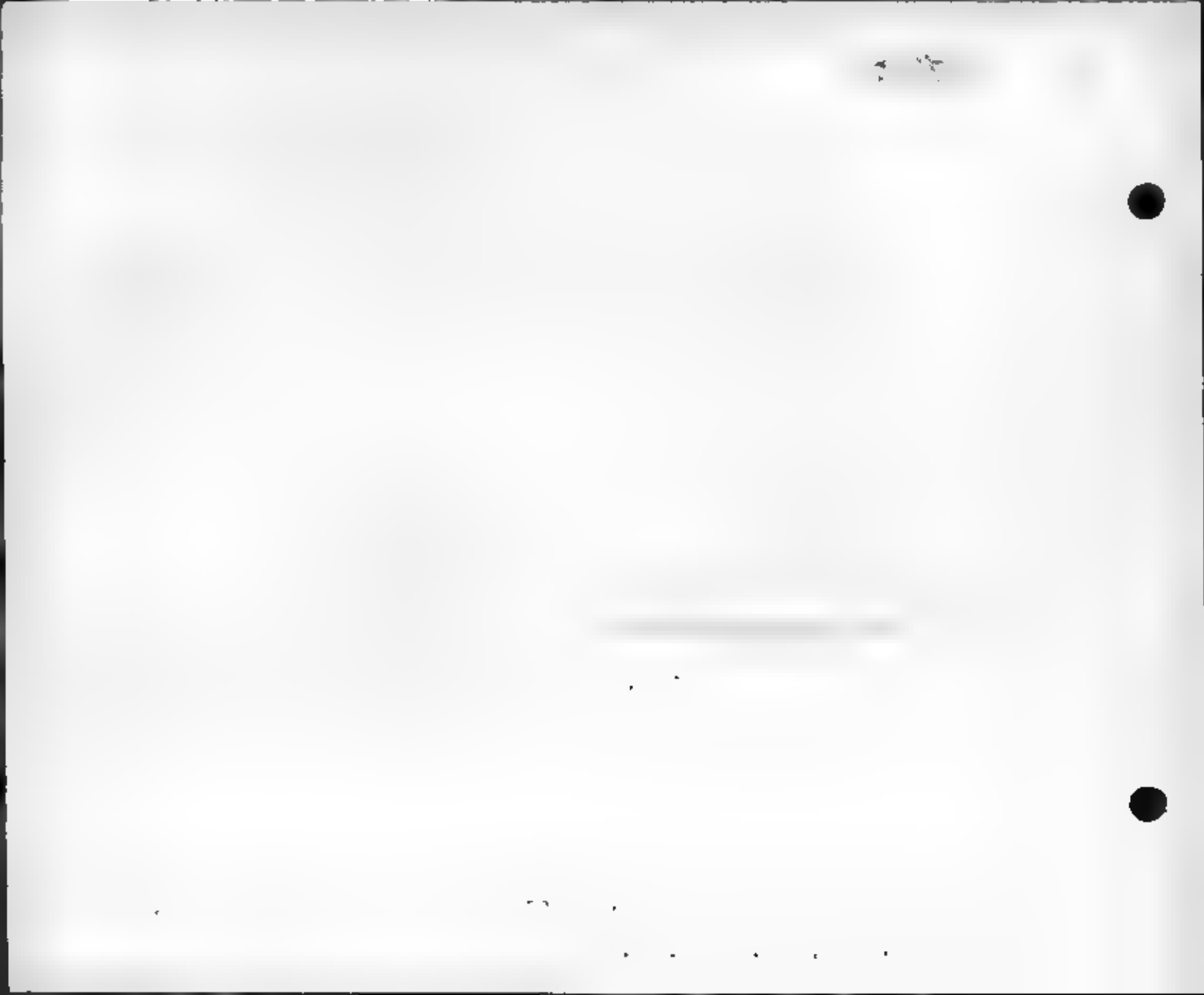
12

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL PUBLIC: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial certificate. Then please remove caution papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town Towson		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Baltimore		3. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
c. CITY OR TOWN if outside corporate limits write RURAL and give nearest town Towson		d. NAME OF HOSPITAL OR INSTITUTION if not in hospital, give street address Dulaney Towson Nursing Home		e. STREET ADDRESS 16 Ridgemoor Road		f. DATE OF DEATH Month June Day 13 Year 1967		g. AGE in years (last birthday) 66 yrs IF UNDER 1 YEAR: Months 6 Days 13 Hours 19 Min.	
3. NAME OF DECEASED (Type or print) Kenneth R Bourn		4. DATE OF DEATH Month June Day 13 Year 1967		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH Nov 23, 1900		9. AGE in years (last birthday) 66 yrs		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Engineer		11. BIRTHPLACE (County & State, or foreign country) Templeton, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T. Bourn		14. MOTHER'S MARRIAGE NAME Carrie Cummings		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. EMPLOYMENT Dulaney Towson Nursing Home, 111 West Road	
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). CEREBROVASCULAR ACCIDENT CONDITIONS, if any which gave rise to immediate cause (a), stating the underlying cause next. CEREBRAL ARTERIOSCLEROSIS (PREVIOUS STROKE)		19. INTERVAL BETWEEN ONSET AND DEATH MINUTES		20. PART I. OTHERS ON FATAL CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) UREMIA		21. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell at home		20c. TIME OF INJURY Month, Day, Year June 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home	
20f. (City or town) (County) (State)		21. I certify that I (this hospital) attended the deceased from 6/12/67 to 6/13/67 , that I (we) last saw the deceased alive on 6/12/67 , and that death occurred at Local M. from the causes and on the date stated above.		22a. SIGNATURE Donald L. Somerville		22b. DATE SIGNED 6/13/67			
22c. PHYSICIAN'S NAME (TYPE) DONALD L. SOMERVILLE MD. TOWSON, MD 21204		22d. ADDRESS		23a. BURIAL CREMATION Removal		23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY Univ. of Vermont Medical School, Burlington, Vermont.	
23d. LOCATION (City town or county) (State)		24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24a. ADDRESS		24b. REC'D BY REG' STRAN		24c. REGISTRAR'S SIGNATURE	
24d. DATE JUN 14 1967									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. It is necessary to file this certificate with the word "pending" in the "Cause of Death" section. Pages 2 and 3 of the certificate are for Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit, permit Free pages, and 24 hours after death.

VA FORM 101
REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07630

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE Where decedent resided at time of death a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
3. CITY OR TOWN If inside corporate limits write RIRA and give street address <u>Catonsville</u>		4. CITY OR TOWN If outside corporate limits write RIRA and give street address <u>Catonsville</u>	
5. NAME OF HOSPITAL, OR INSTITUTION If not a hospital give street address <u>2 Monmouth Rd. Catonsville</u>		6. REF. ADDR. <u>#2 Monmouth Rd. Catonsville</u>	
7. NAME OF DECEASED a. FIRST NAME <u>Catherine</u> b. MIDDLE NAME <u>H.</u> c. LAST NAME <u>Bradley</u>		8. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1967</u>	
9. SEX <u>F</u> 10. COLOR OR RACE <u>W</u> 11. MARRIED <input type="checkbox"/> 12. IF MARRIED <input type="checkbox"/> 13. DIVORCED <input type="checkbox"/> 14. WIDOWED <input checked="" type="checkbox"/> 15. BIRTHDAY <u>Dec. 11, 1905</u>		16. BIRTHPLACE <u>Baltimore Md.</u> 17. IF WHAT BY <u>L.S.A.</u>	
18. OCCUPATION <u>Self-employed</u> 19. RELATIONSHIP TO DECEASED <u>Confectionery</u>		20. BIRTHPLACE <u>Baltimore Md.</u> 21. IF WHAT BY <u>L.S.A.</u>	
22. FATHER'S NAME <u>Otto Hinterpessch</u>		23. MOTHER'S NAME <u>Larrie ?</u>	
24. SOCIAL SECURITY NO. <u>no</u>		25. ADDRESS <u>212-42-4526A Charles H. Mansfield Blomont Rd.</u>	
26. CAUSE OF DEATH (a) <u>Cardio Vascular Accident</u> (b) <u>Hypertension</u>		27. <u>Cardio-Vascular Disease</u>	
28. PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 29. <u>Cardio-Vascular Disease</u>		30. <u>Cardio-Vascular Disease</u>	
31. <u>Cardio-Vascular Disease</u>		32. <u>Cardio-Vascular Disease</u>	
33. <u>Cardio-Vascular Disease</u>		34. <u>Cardio-Vascular Disease</u>	
35. <u>Cardio-Vascular Disease</u>		36. <u>Cardio-Vascular Disease</u>	
37. <u>Cardio-Vascular Disease</u>		38. <u>Cardio-Vascular Disease</u>	
39. <u>Cardio-Vascular Disease</u>		40. <u>Cardio-Vascular Disease</u>	
41. <u>Cardio-Vascular Disease</u>		42. <u>Cardio-Vascular Disease</u>	
43. <u>Cardio-Vascular Disease</u>		44. <u>Cardio-Vascular Disease</u>	
45. <u>Cardio-Vascular Disease</u>		46. <u>Cardio-Vascular Disease</u>	
47. <u>Cardio-Vascular Disease</u>		48. <u>Cardio-Vascular Disease</u>	
49. <u>Cardio-Vascular Disease</u>		50. <u>Cardio-Vascular Disease</u>	
51. <u>Cardio-Vascular Disease</u>		52. <u>Cardio-Vascular Disease</u>	
53. <u>Cardio-Vascular Disease</u>		54. <u>Cardio-Vascular Disease</u>	
55. <u>Cardio-Vascular Disease</u>		56. <u>Cardio-Vascular Disease</u>	
57. <u>Cardio-Vascular Disease</u>		58. <u>Cardio-Vascular Disease</u>	
59. <u>Cardio-Vascular Disease</u>		60. <u>Cardio-Vascular Disease</u>	
61. <u>Cardio-Vascular Disease</u>		62. <u>Cardio-Vascular Disease</u>	
63. <u>Cardio-Vascular Disease</u>		64. <u>Cardio-Vascular Disease</u>	
65. <u>Cardio-Vascular Disease</u>		66. <u>Cardio-Vascular Disease</u>	
67. <u>Cardio-Vascular Disease</u>		68. <u>Cardio-Vascular Disease</u>	
69. <u>Cardio-Vascular Disease</u>		70. <u>Cardio-Vascular Disease</u>	
71. <u>Cardio-Vascular Disease</u>		72. <u>Cardio-Vascular Disease</u>	
73. <u>Cardio-Vascular Disease</u>		74. <u>Cardio-Vascular Disease</u>	
75. <u>Cardio-Vascular Disease</u>		76. <u>Cardio-Vascular Disease</u>	
77. <u>Cardio-Vascular Disease</u>		78. <u>Cardio-Vascular Disease</u>	
79. <u>Cardio-Vascular Disease</u>		80. <u>Cardio-Vascular Disease</u>	
81. <u>Cardio-Vascular Disease</u>		82. <u>Cardio-Vascular Disease</u>	
83. <u>Cardio-Vascular Disease</u>		84. <u>Cardio-Vascular Disease</u>	
85. <u>Cardio-Vascular Disease</u>		86. <u>Cardio-Vascular Disease</u>	
87. <u>Cardio-Vascular Disease</u>		88. <u>Cardio-Vascular Disease</u>	
89. <u>Cardio-Vascular Disease</u>		90. <u>Cardio-Vascular Disease</u>	
91. <u>Cardio-Vascular Disease</u>		92. <u>Cardio-Vascular Disease</u>	
93. <u>Cardio-Vascular Disease</u>		94. <u>Cardio-Vascular Disease</u>	
95. <u>Cardio-Vascular Disease</u>		96. <u>Cardio-Vascular Disease</u>	
97. <u>Cardio-Vascular Disease</u>		98. <u>Cardio-Vascular Disease</u>	
99. <u>Cardio-Vascular Disease</u>		100. <u>Cardio-Vascular Disease</u>	

ACTUAL SIGNATURE James N. Frederick
EXAMINER'S NAME James N. Frederick

22. DATE SIGNED 6/15/67
23. Cardio-Vascular Disease

24. Cardio-Vascular Disease 25. Cardio-Vascular Disease 26. Cardio-Vascular Disease
27. Cardio-Vascular Disease 28. Cardio-Vascular Disease 29. Cardio-Vascular Disease
30. Cardio-Vascular Disease 31. Cardio-Vascular Disease 32. Cardio-Vascular Disease
33. Cardio-Vascular Disease 34. Cardio-Vascular Disease 35. Cardio-Vascular Disease
36. Cardio-Vascular Disease 37. Cardio-Vascular Disease 38. Cardio-Vascular Disease
39. Cardio-Vascular Disease 40. Cardio-Vascular Disease 41. Cardio-Vascular Disease
42. Cardio-Vascular Disease 43. Cardio-Vascular Disease 44. Cardio-Vascular Disease
45. Cardio-Vascular Disease 46. Cardio-Vascular Disease 47. Cardio-Vascular Disease
48. Cardio-Vascular Disease 49. Cardio-Vascular Disease 50. Cardio-Vascular Disease
51. Cardio-Vascular Disease 52. Cardio-Vascular Disease 53. Cardio-Vascular Disease
54. Cardio-Vascular Disease 55. Cardio-Vascular Disease 56. Cardio-Vascular Disease
57. Cardio-Vascular Disease 58. Cardio-Vascular Disease 59. Cardio-Vascular Disease
60. Cardio-Vascular Disease 61. Cardio-Vascular Disease 62. Cardio-Vascular Disease
63. Cardio-Vascular Disease 64. Cardio-Vascular Disease 65. Cardio-Vascular Disease
66. Cardio-Vascular Disease 67. Cardio-Vascular Disease 68. Cardio-Vascular Disease
69. Cardio-Vascular Disease 70. Cardio-Vascular Disease 71. Cardio-Vascular Disease
72. Cardio-Vascular Disease 73. Cardio-Vascular Disease 74. Cardio-Vascular Disease
75. Cardio-Vascular Disease 76. Cardio-Vascular Disease 77. Cardio-Vascular Disease
78. Cardio-Vascular Disease 79. Cardio-Vascular Disease 80. Cardio-Vascular Disease
81. Cardio-Vascular Disease 82. Cardio-Vascular Disease 83. Cardio-Vascular Disease
84. Cardio-Vascular Disease 85. Cardio-Vascular Disease 86. Cardio-Vascular Disease
87. Cardio-Vascular Disease 88. Cardio-Vascular Disease 89. Cardio-Vascular Disease
90. Cardio-Vascular Disease 91. Cardio-Vascular Disease 92. Cardio-Vascular Disease
93. Cardio-Vascular Disease 94. Cardio-Vascular Disease 95. Cardio-Vascular Disease
96. Cardio-Vascular Disease 97. Cardio-Vascular Disease 98. Cardio-Vascular Disease
99. Cardio-Vascular Disease 100. Cardio-Vascular Disease



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

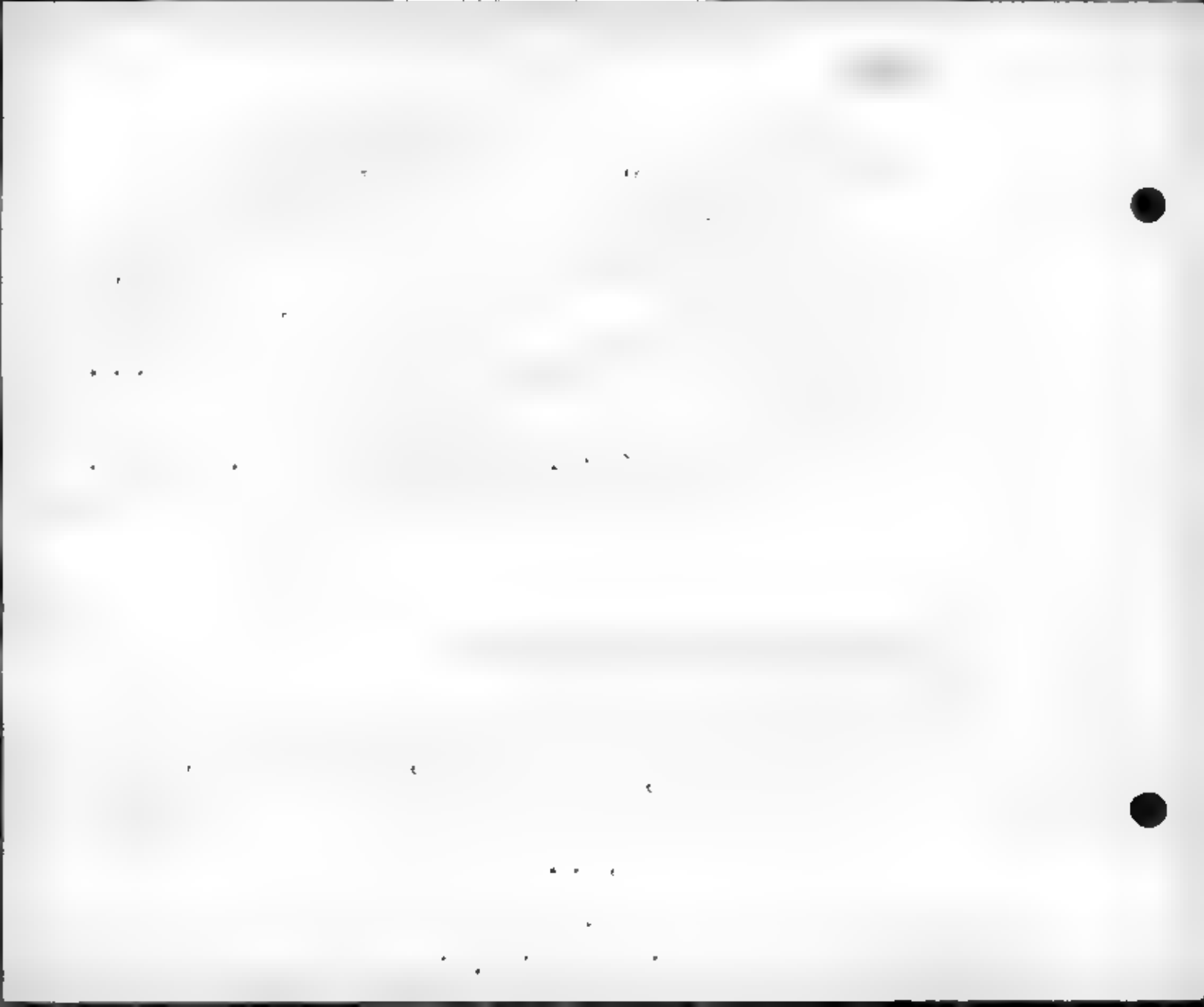
07699

CERTIFICATE OF DEATH

07681

PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		USUAL RESIDENCE Where deceased lived (institution, Residence before admission) a STATE MARYLAND b COUNTY	
b CITY OR TOWN If outside corporate limits, write RURAL and give nearest town PORT HOWARD		c CITY OR TOWN If outside corporate limits, write RURAL and give nearest town BALTIMORE	
d NAME OF HOSPITAL OR IN INSTITUTION If not in hospital, give street address VETERANS ADMINISTRATION HOSPITAL		e STREET ADDRESS 606 RADNOR AVENUE	
f NAME OF DECEASED (Type or print) CHARLES AGUSTUS ERANSON		g DATE OF DEATH Month JUNE Day 2 Year 1967	
h SEX MALE	i COLOR OR RACE NEGRO	j DATE OF BIRTH 3/10/96	k AGE in years, months, days, hours, minutes 71
l OCCUPATION (Give kind of work done during one year at least, or ever if retired) CHAUFFEUR		m BIRTHPLACE (Country & State of origin; or city, town, or village) CWINGS MILLS, MARYLAND	
n FATHER NAME JAMES ERANSON		o MOTHER NAME NANNIE DAVIS	
p MARITAL STATUS (If ever married, give date of service) YES WIDOW		q SOCIAL SECURITY NO 218 12 73 61	
r CAUSE OF DEATH (If only one, give part one for cause and part two for death was caused by) CEREBRAL HEMORRHAGE		s INTERVAL BETWEEN DEATH AND EXAMINATION UNKNOWN	
t OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If any, which gave rise to immediate cause of death, or the underlying cause) ARTERIOSCLEROTIC HEART DISEASE AND PNEUMONIA			
u INJURY (If any, which gave rise to immediate cause of death, or the underlying cause) NO		v DESCRIBE HOW INJURY OCCURRED (If any, which gave rise to immediate cause of death, or the underlying cause) NO	
w INJURY (If any, which gave rise to immediate cause of death, or the underlying cause) NO		x PLACE OF INJURY (If any, which gave rise to immediate cause of death, or the underlying cause) NO	
y I certify that this hospital attended the deceased from MAY 19, 1967 to JUNE 2, 1967 and that death occurred at 5:15 AM from cause and on the date stated above.			
z SIGNATURE OF PHYSICIAN Paulino D. Deocampo		aa DATE OF DEATH 6/2/67	
ab PHYSICIAN'S NAME (Type) PAULINO D. DEOCAMPO, M.D.		ac ADDRESS VA HOSPITAL, PORT HOWARD, MARYLAND	
ad PLACE OF BURIAL BALTO. NATIONAL CEMETERY		ae CITY OR TOWN BALTIMORE, MARYLAND	
af FUNERAL HOME NUTTER FUNERAL HOME, 3035 W. NORTH AVE., BALTO., MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please send it to the funeral home for page 3 and 4. The funeral home will then file it with the Department of Health and send it to the State Department of Health.



TO HOSPITAL OR ATTENDING PHYSICIAN The inv. requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hosp. or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the inv. by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 2 and return them to the State Dept. of Health prior to burial or cremation or removal and to an event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07700

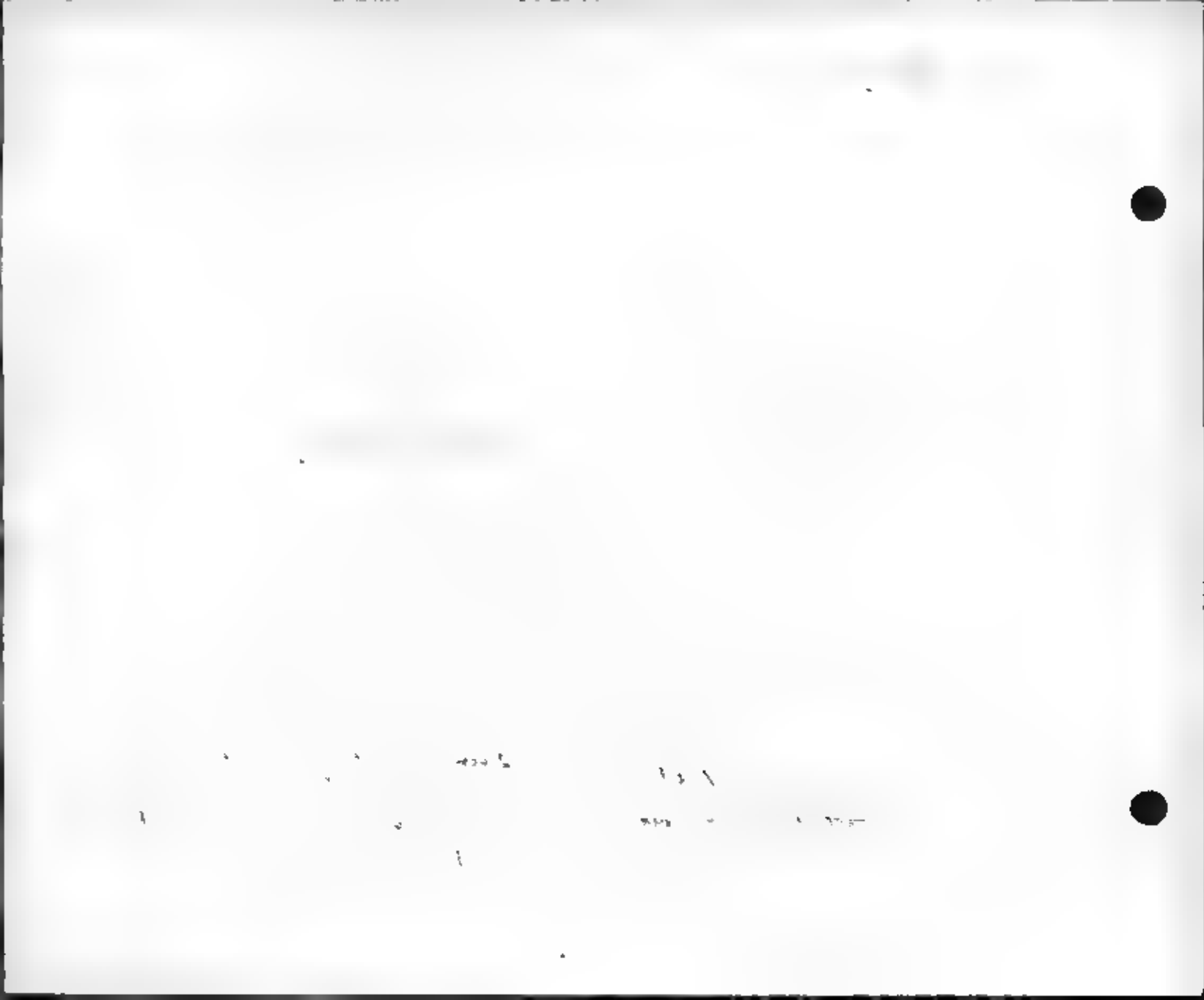
CERTIFICATE OF DEATH

07682

1 PLACE OF DEATH a COUNTY Baltimore		b CITY OR TOWN Catonsville		c LENGTH OF STAY IN b 1		1 USUAL RESIDENCE (where deceased lived if inst'd on residence before admission) a STATE MD.		b COUNTY Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hagerman's Pines Catonsville		e STREET ADDRESS 16 Rustling Ave.		f IF RESIDENCE ON A FARM a YES <input type="checkbox"/> NO <input type="checkbox"/>		3 NAME OF DECEASED (Type or print) First Middle Last Anna M. Brockman		4 DATE OF DEATH Month Day Year June 16 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 24 1877	9 AGE in years last birthday 89	10 FINDER YEAR Month Day Year June 16 1967	11 IF UNDER 18 Hours M 11 00	12a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY	13 BIRTHPLACE (County & State or foreign country) Maryland
13 FATHER'S NAME George Myers		14 MOTHER'S MAIDEN NAME Annie		15 INFORMANT Richard P. Gilport		16 ADDRESS 506 Equitable Bldg.		17 WAS DECEASED EVER IN U.S. ARMED SERVICES (Yes, no, or unknown) (If yes, give word or dates of service)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer DUE TO Obstruction Conditions any which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic DUE TO Arteriosclerosis (c) Heart		19 INTERVAL BETWEEN ONSET AND DEATH 1 Year		20 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) High blood pressure		21 WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/>		22a a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hh. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tt. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz.	

25a REF'D BY REGISTRAR
JUN 20 1967

25b REGISTRAR'S SIGNATURE
Charles Judge



TO DEPUTY MEDICAL EXAMINER. The report should be expedited with a 24 hours after death if possible. Please use the placard we are waiting the word pending in person in item 18 Give Pages 1 2 the final report to the Chief Medical Examiner Office along with form 10-104.5 and a copy to the Director. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Charles Judge

100



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

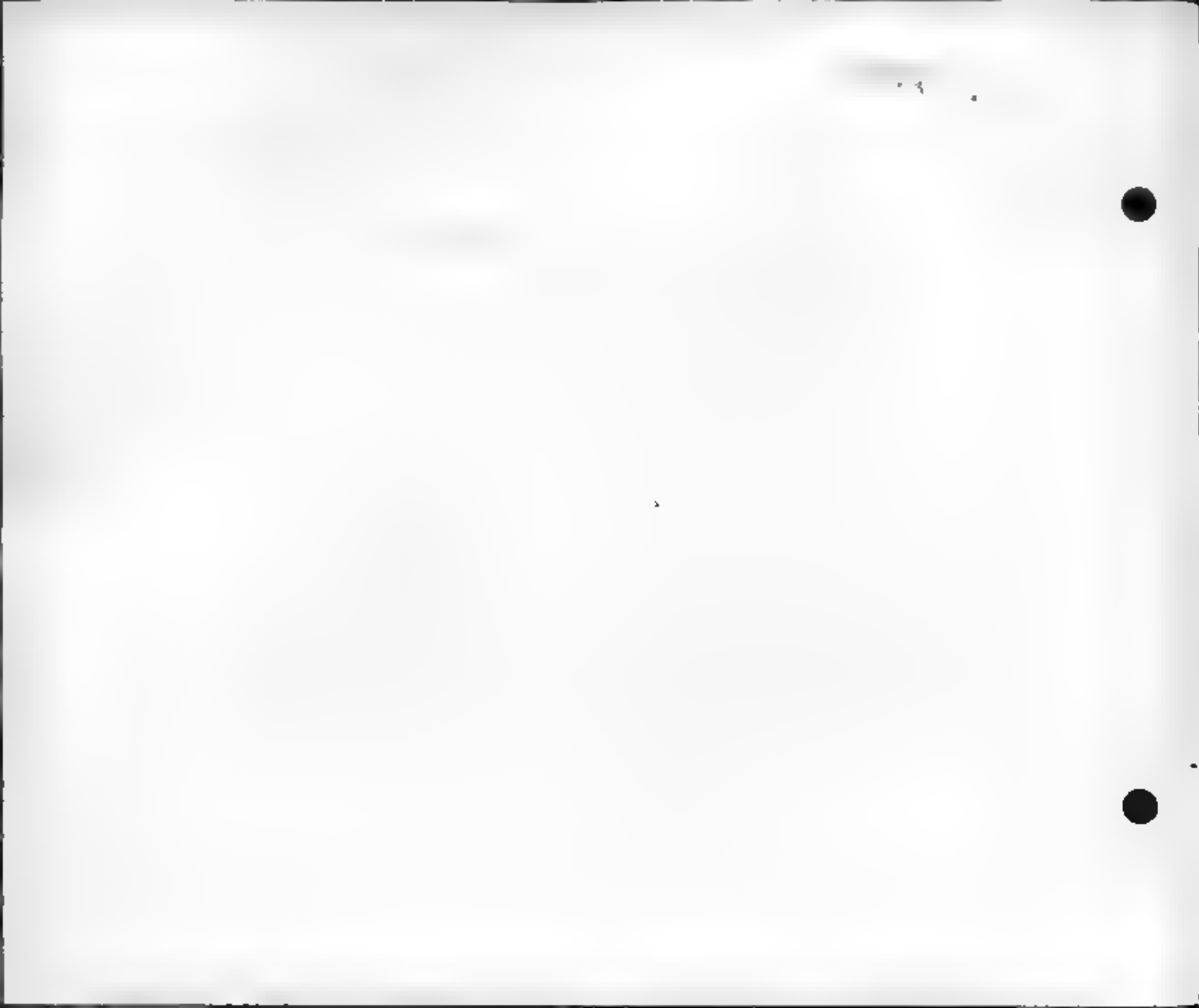
07768

CERTIFICATE OF DEATH

07684

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hour after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please forward the paper, pages 1, 2, and 3, to the funeral director who should be filed with the State Dept of Health prior to burial or cremation or removal, and when even within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. NAME OF HOSPITAL OR INST. IF THEN (If not in hospital, give street address) 3111 Hammonds Ferry Road 21227		d. STREET ADDRESS 3111 Hammonds Ferry Road	
3 NAME OF DECEASED Type of print: PERCY R. BROOKS		4 DATE OF DEATH Month June Day 22 Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-7-1896
9a. Usual occupation (Give kind of work done during most of working life, even if retired) Retired		9b. AGE in years last birthday 70	
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & state or foreign country) Maryland	
12. FATHER NAME Hesson Brooks		13. MOTHER'S MAIDEN NAME Amenda Radden	
14. SOCIAL SECURITY NO. 212-07-3772		15. INFORMANT Mrs. Virginia C. Brooks, 3111 Hammonds Ferry Rd.	
16. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO CONDITIONS (if any) which gave rise to immediate cause (a), setting the underlying cause (b) DUE TO 17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART 16) Minimal chronic pulmonary tuberculosis		18. MANNER OF DEATH a. SUICIDE <input type="checkbox"/> b. ACCIDENT <input type="checkbox"/> c. HOMICIDE <input type="checkbox"/> d. UNNATURAL <input type="checkbox"/> e. NATURAL <input checked="" type="checkbox"/> f. UNKNOWN <input type="checkbox"/>	
19. TIME OF INJURY (Month Day Year) Month 6 Day 19 Year 67		20. PLACE OF INJURY (Home, farm, office, etc.) Home	
21. I certify that the deceased attended the deceased from April 1953 to 6-22-67 that I saw the deceased alive on 6-19-67 and that death occurred at A.M. on the date stated above.		22. SIGNATURE Dr. Wm. Carl Ebeling Dr. Robert C. Duvall	
23a. BURIAL OR CREMATION b. DATE THEREOF 6-24-1967		24. NAME OF CEMETERY OR CREMATOR Meadowridge Cemetery	
25a. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25b. REGISTRY BY REGISTRAR June 22 1967	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

97703

27635

PLACE OF DEATH
a. COUNTY Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
Baltimore

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
FILED, ON

d. STREET ADDRESS
415 Liberty Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1. NAME OF DECEASED (Type or Print) William L. Brooks

2. SEX M 3. COLOR OR RACE W 4. MARRIED ☒ NEVER MARRIED ☐ 5. DATE OF BIRTH 8/23/61

6. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STEEL

7. KIND OF BUSINESS OR INDUSTRY STEEL

8. BIRTHPLACE (County & State, or foreign country)
Baltimore

9. CITIZEN OF WHAT COUNTRY?
U.S.A.

10. FATHER'S NAME Wm Henry Brooks

11. MOTHER'S MAIDEN NAME Helen

12. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No

13. SOCIAL SECURITY NO. 57-04-1814-A

14. INFORMANT Helen K Brooks

15. ADDRESS 415 Liberty Rd.

16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Pulmonary Disease
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Pulmonary Disease
DUE TO (c) Chronic Pulmonary Disease

17. PART II. OTHERS ON SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Pulmonary Disease

18. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

19. AGE DECEASED WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20b. TIME OF INJURY Month Day Year
20c. INJURY OCCURRED While ☐ Not While ☐
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20e. CITY OR TOWN (County) (State)

21. I certify that (1) the hospital attended the deceased from 5-24, 1967, to 6-8, 1967, that (2) we last saw the deceased alive on 6-8, 1967, and that death occurred at 9:11 M. from the causes and on the date stated above.

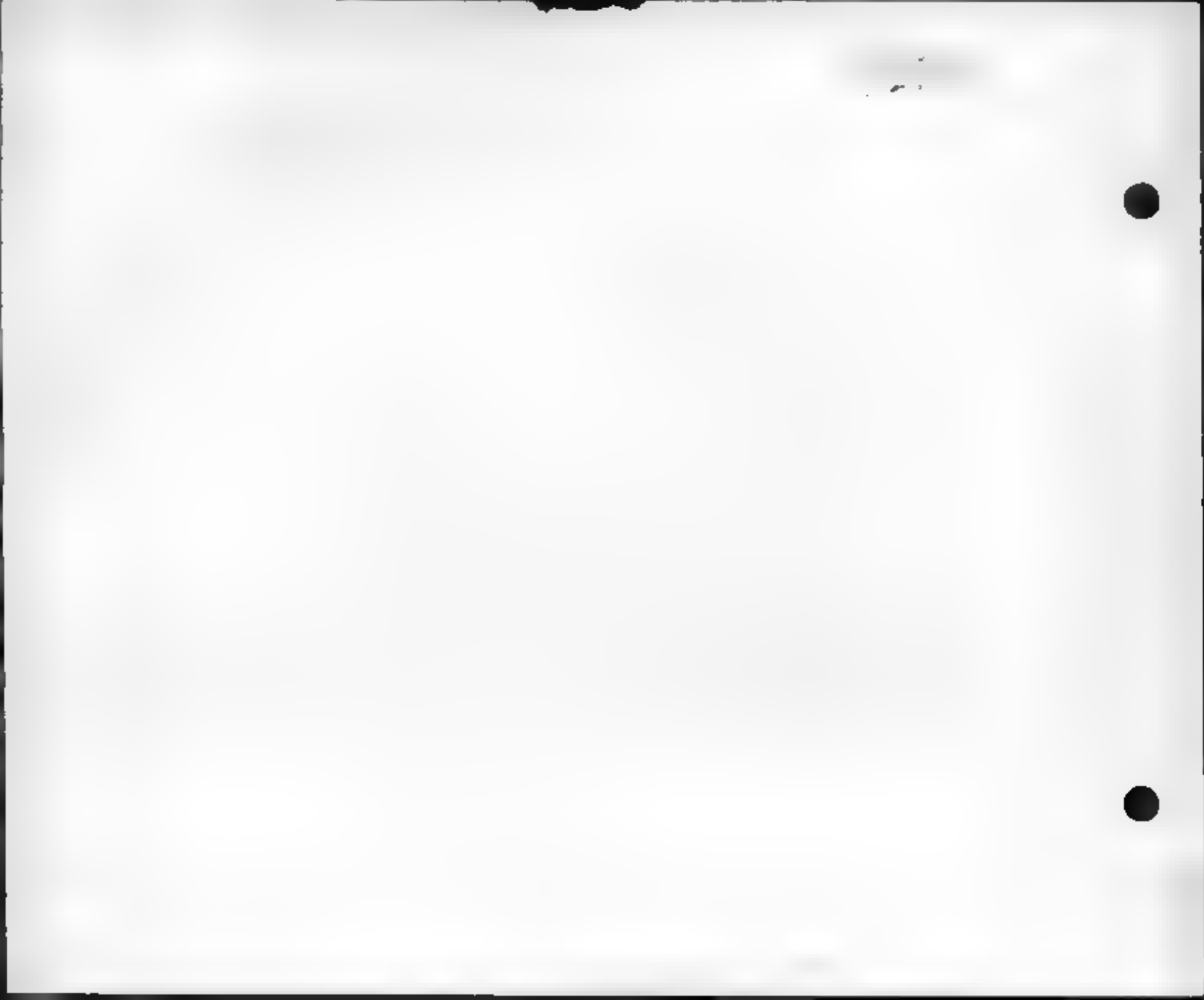
22a. SIGNATURE Wm L. Brooks M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 6-8-67

22c. PHYSICIAN'S NAME (Type) Wm L. Brooks 22d. ADDRESS 415 Liberty Rd.

23a. BURIAL CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-12-67 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery - Baltimore Md. 23d. LOCATION (City, town or county) (State) Baltimore Md.

24. FUNERAL DIRECTOR Ellsworth Armacost 25a. RECEIVED BY REGISTRAR Ellsworth Armacost 25b. REGISTRAR'S SIGNATURE Ellsworth Armacost

26. DATE JUN 12 1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07636

07704

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. STATE Maryland		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN Baltimore d. STREET ADDRESS 29 West Elm Avenue	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		4. DATE OF DEATH Month 6 Day 26 Year 1967	
5. NAME OF DECEASED First CECIL Middle ARTHUR Last BROWN		6. DATE OF BIRTH Month 9 Day 1 Year 1893	
7. SEX Male		8. RACE Caucasian	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BIRTHPLACE (County & State of foreign country) Baltimore, Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY B.O. Railroad	
13. FATHER'S NAME William Fran Brown		14. MOTHER'S MAIDEN NAME Eleanor Mc Clanahan	
15. WAS RELEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-07-8882	
17. INFORMANT Patient chart		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung. DUE TO Conditions, if any, which gave rise to immediate cause (b) causing the underlying cause (c) DUE TO 6	
19. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I 20a. AGE AT DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF OTHER THAN MEDICAL EXAMINER 20b. DESCRIBE HOW INJURY OCCURRED 20c. PART OF INJURY 20d. PLACE OF INJURY 20e. CITY OR TOWN		21. INTERVAL BETWEEN INJURY AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that this hospital attended the deceased from June 13, 1967 to June 26, 1967 that we last saw the deceased alive on June 27, 1967 and that death occurred at 12:40 PM from causes and on the date stated above		23. SIGNATURE John E. Adams M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> TELLER <input checked="" type="checkbox"/> 6/26/67	
24. PHYSICIAN'S NAME John E. Adams, M.D.		25. ADDRESS Greater Baltimore Medical Center	
26. BURIAL REMOVAL SPECIFY Burial		27. DATE 6-29-1967	
28. NAME OF CEMETERY OR BURIAL PLACE Parkwood Cemetery		29. CITY OR TOWN Baltimore	
30. ADDRESS Lassahn Funeral Home 740, Belair Road		31. REC'D BY REGISTRAR June 26, 1967	
32. REGISTRAR'S SIGNATURE Charles J. [Signature]		33. DATE June 26, 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the official transit permit. Then please remove carbon papers, pages and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTEND NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

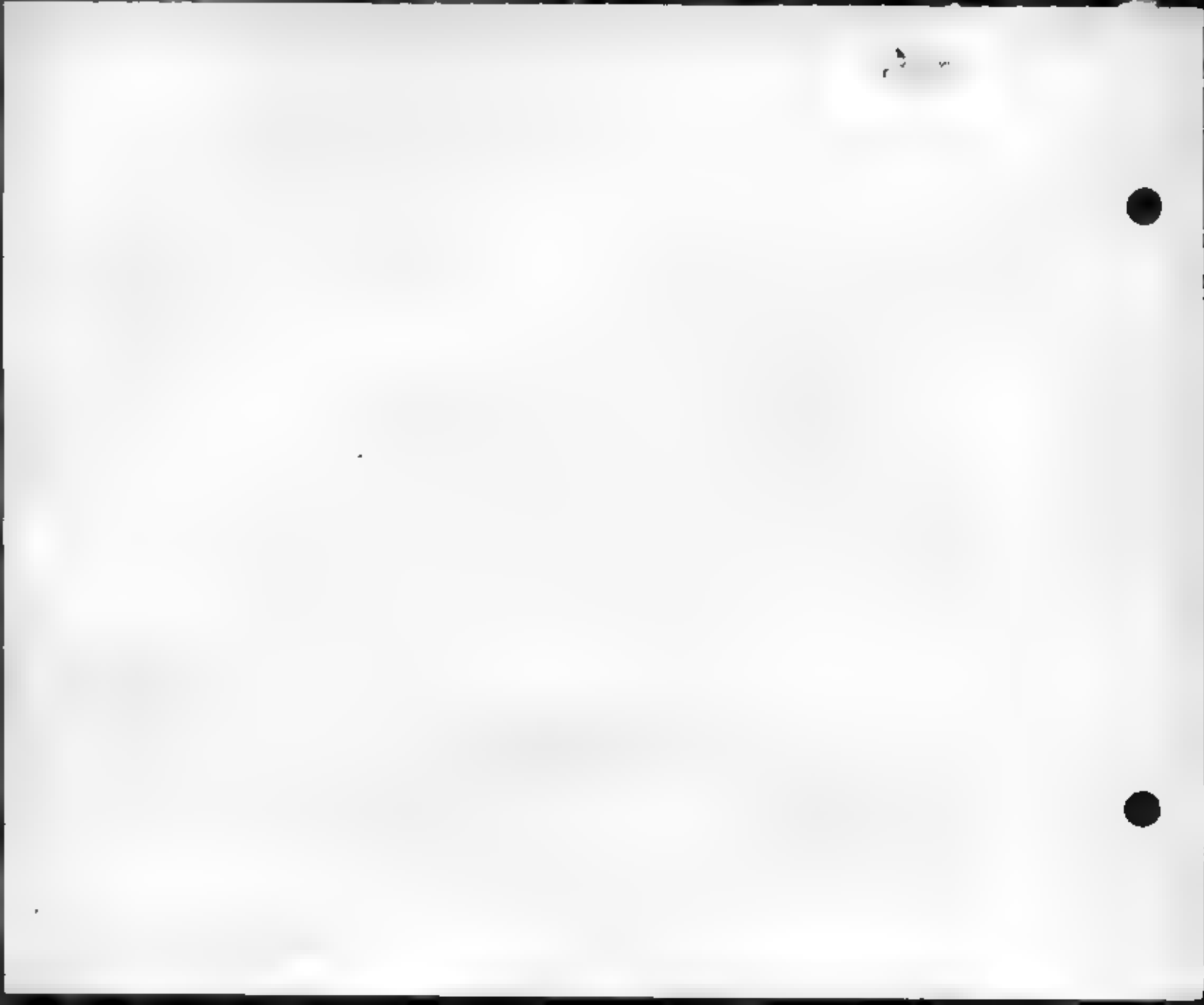
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial and permit. The funeral director should remove carbon page 3, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

27705

57687

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. NAME OF HOSPITAL OR INST. (if not in hospital, give street address) DULANEY TOWSON NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHITE MARSH d. STREET ADDRESS Box 38 Ebenezer RD	
3. NAME OF DECEASED (Type or print) L. NOS BROWN		4. DATE OF DEATH 6 10 1967	
5. SEX MALE 6. COLOR OF RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 7/29/03 9. AGE (in years last birthday) 63 yrs FINDER 1 YEAR Months Days FINDER 24 HRS Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIN TENANCE AIRCRAFT 11. BIRTHPLACE (County & State, or foreign country) PLACER VALLEY WYO. USA 12. COUNTRY OF WHAT COUNTRY	
13. FATHER'S NAME OLIE BROWN		14. MOTHER'S MARDEN NAME SARAH LACEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO 77-75-2394		17. INFORMANT Mrs Carville Akehurst Ebenezer Road 2, 62	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHERS ON SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONING VEN IMPART (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I c. Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year April 21, 1967 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY Home, farm, factory, street office bldg, etc. Lockport 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1967 to June 10, 1967 that (I) (we) last saw the deceased alive on 6-9-1967 and that death occurred at 12:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Frank E. Kuehn 22b. PHYSICIAN'S NAME FRANK E. KUEHN		22c. ADDRESS 221 MED ARTS BLDG 21201	
23a. BURIAL CREMATION, RE-OVAL, SPECHY burial 23b. DATE THEREOF 6-14-1967 23c. NAME OF CEMETERY OR CREMATORY Cold Spring Cemetery 23d. LOCATION (City, town or county) (State) Lockport N.Y.		24. FUNERAL DIRECTOR John J. ... 25. REC'D BY REG STRAR JUN 14 1967 25b. REGISTER'S SIGNATURE John J. ...	



FOR STATE
HEALTH DEPT

Item 1 of 1111
MAYLAND AND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 30 W PRESTON STREET BALTIMORE MARYLAND 21201

07706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07688

PLACE OF DEATH
COUNTY

BALTIMORE

MARYLAND

USUAL RESIDENCE Where born

Maryland

BALTIMORE

Baltimore

St. Joseph Hospital

405 Warren Avenue

NAME OF
DECEASED

WILLIAM

OSCAR

Subser BLUSER

DATE
OF
DEATH

June

17, 1967

Male

White

MARRIED

WIDOW

WIDOW

July 19, 1928

Insurance

Brokerage

Chicago, Ill

FATHER'S NAME

William J. Subser

MOTHER'S MAIDEN NAME

Eva Riddle

Yes

Discharged 1948 322-24-6466

INFORMANT

W. H. Leonhart 38 South St.

CAUSE OF DEATH
PART DEATH WAS CAUSED BY

Drowning

117.4
(Conditions, if any, which gave
rise to immediate use
of the foregoing code)

DUE TO

Acute ethylism

Found underwater at west end of pool

2 I certify that

acknowledge the accuracy of the information furnished

How made

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

June 18, 1967

EXAMINER'S
NAME

Burial

6/21/1967

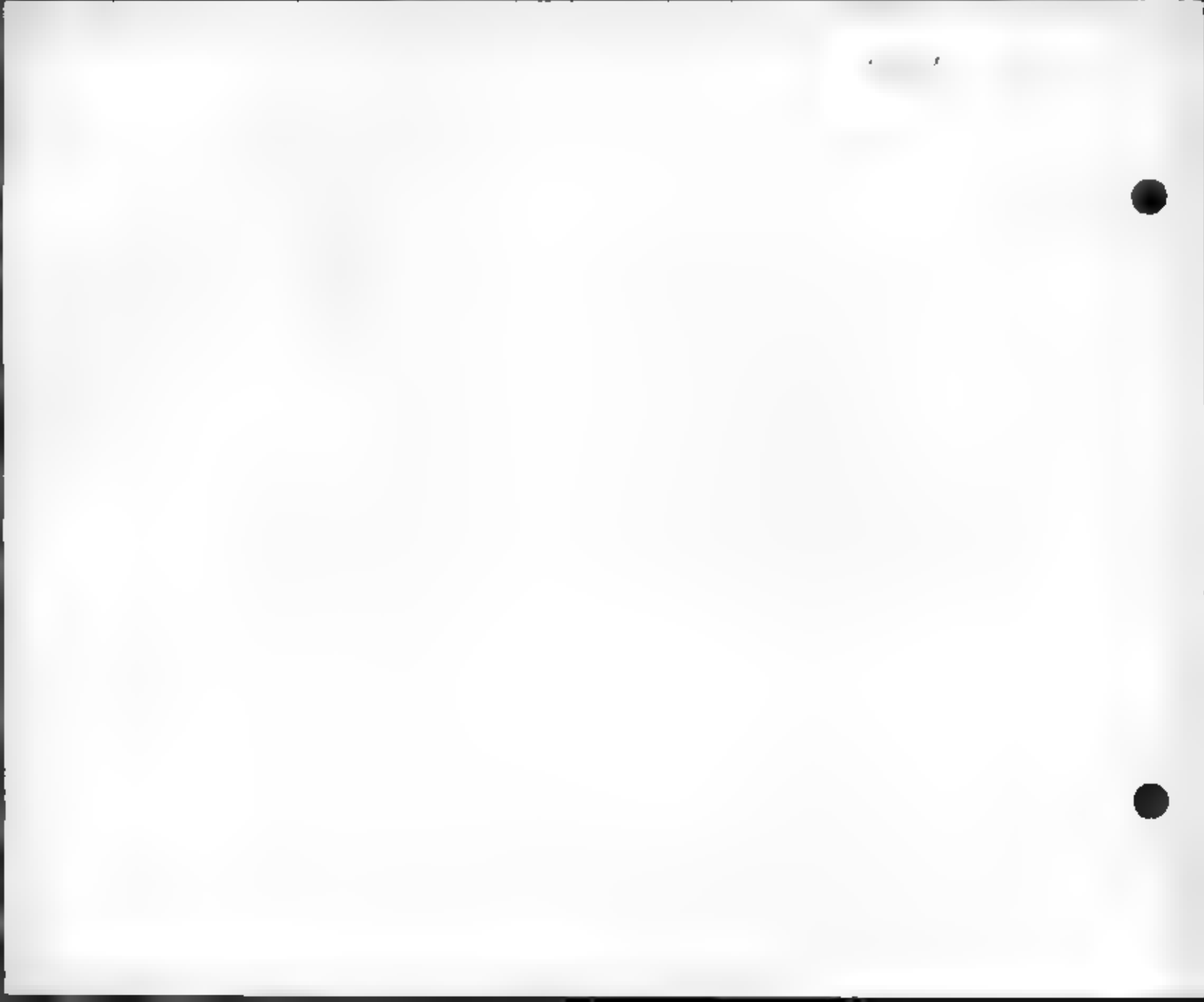
Chicago, Ill.

Eugenia K. Seitz 5209 York Road Balto. Md.

20 1967

Charles Springate

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours of the death of the decedent. It should be filed with the health department within 72 hours of the death. The undersigned hereby certifies that the information furnished is true and correct. Page 4 of 4. TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit and removed within 72 hours of the death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER This certificate should be forwarded to the Chief Medical Examiner's Office at the State Department of Health, 301 W. Preston Street, Baltimore, Maryland 21201, for filing and distribution. It should be filed with the death certificate and the medical examiner's report. It should be filed with the death certificate and the medical examiner's report. It should be filed with the death certificate and the medical examiner's report.

07707		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201		07689	
PLACE OF DEATH Baltimore		USUAL RESIDENCE 2nd City		BALTO.	
NAME OF DECEASED DELLA BLANCHE BUCKINGHAM		DATE OF DEATH June 3 1967		AGE 67	
SEX Female		RACE White		MARRIAGE MARRIED	
BIRTH DATE 11-20-'81		BIRTH PLACE Carroll Co., Md.		MOTHER'S MAIDEN NAME Emma Shauach	
FATHER'S NAME Alfred T. Buckingham		MOTHER'S NAME Emma Shauach		INFORMANT Forkleigh Nursing Home Records - Harrison	
CAUSE OF DEATH arteriosclerotic C-V Disease		CONDITIONS, if any, which gave rise to immediate cause (e) stating the underlying cause		2 yrs.	
PAR II OTHER UNIFORM OR OTHERS		FRACTURED RT HIP		Fell on floor at home	
201 DECEASED HOW IN RE		202 PLACE OF DEATH		203 DATE OF DEATH	
3-3-67		Home		Baltimore	
2 I certify that		204 DATE SIGNED		6-3-67	
205 SIGNATURE		206 NAME OF EXAMINER		207 DATE SIGNED	
D. D. CAPLES		D. D. CAPLES		6-3-67	
208 BIRTH DATE		209 NAME OF EXAMINER		210 DATE SIGNED	
6/7/1967		Druid Ridge		Pikesville, Balto. Co. Md.	
211 SIGNATURE		212 NAME OF EXAMINER		213 DATE SIGNED	
H.W. Jenkins & Sons Co.		4905 York Rd.		Balto. 12, Md.	
214 SIGNATURE		215 NAME OF EXAMINER		216 DATE SIGNED	
JUN 5 1967		JUN 5 1967		JUN 5 1967	



W. A. S. 4;
254. 47



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 1, page 3 should be retained by the registrar and page 2 should be filed with the State Dept. of Health. Page 4 should be filed with the State Dept. of Health.

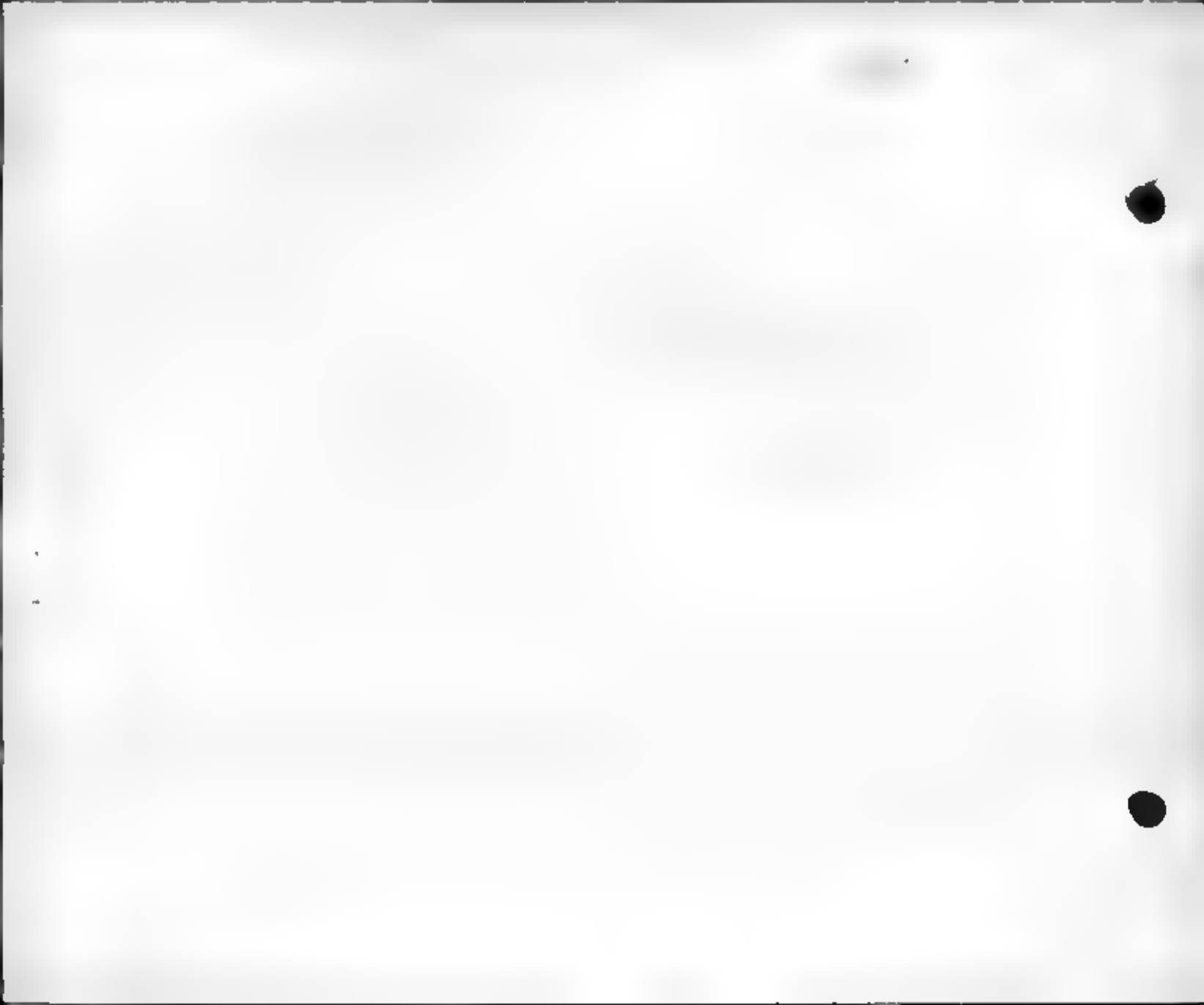
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

07703

CERTIFICATE OF DEATH

37691

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Catonsville		2 USUAL RESIDENCE (Where deceased lived if institut. in residence before admission) a STATE Maryland b COUNTY Harford	
c LENGTH OF STAY IN b 13yr9mth18dys		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Havre deGrace, Maryland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSPITAL		e STREET ADDRESS Box 36	
3 NAME OF DECEASED (Type or print) First Middle Last Claire Healy Bullock		4 DATE OF DEATH Month Day Year June 27 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 28, 1893
9 AGE (In years - last birthday) 75 yrs.		10 UNDER YEAR IF UNDER 24 HR. Months Days Hours Min.	
11 SEXUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		12 KIND OF BUSINESS OR INDUSTRY Massachusetts	
13 FATHER'S NAME John		14 MOTHER'S MAIDEN NAME John	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death 18a 4901 DUE TO Arteriosclerotic Cardiovascular Disease 18b 10 yrs. 18c Arteriosclerosis, generalized, senile 18d 15 yrs.		19 PERIOD BETWEEN DEATH AND DEATH CERTIFICATE	
20a TIME OF DEATH (Month Day Year) June 27 1967		20b INJURY OCCURRED (While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c PLACE OF INJURY (Home farm factory street office bldg. etc.)		20d CITY OR TOWN	
21 I certify that (if this hospital) attended the deceased from Sept. 9 1953 to June 27 1967 and that death occurred at 12:05 PM from causes and on the date stated above.		22 SIGNATURE John A. Bullock M.D.	
23 PHYSICIAN NAME Type John A. Bullock		24 ADDRESS Catonsville, Md. 21228	
25a DATE OF INTERVIEW 7/1/67		25b NAME OF PHYSICIAN OF DEATH George H. Bell	
25c NAME OF PHYSICIAN OF DEATH George H. Bell		25d REGISTERED BY REGISTRAR John A. Bullock	
25e REGISTERED BY REGISTRAR John A. Bullock		25f REGISTRAR SIGNATURE John A. Bullock	

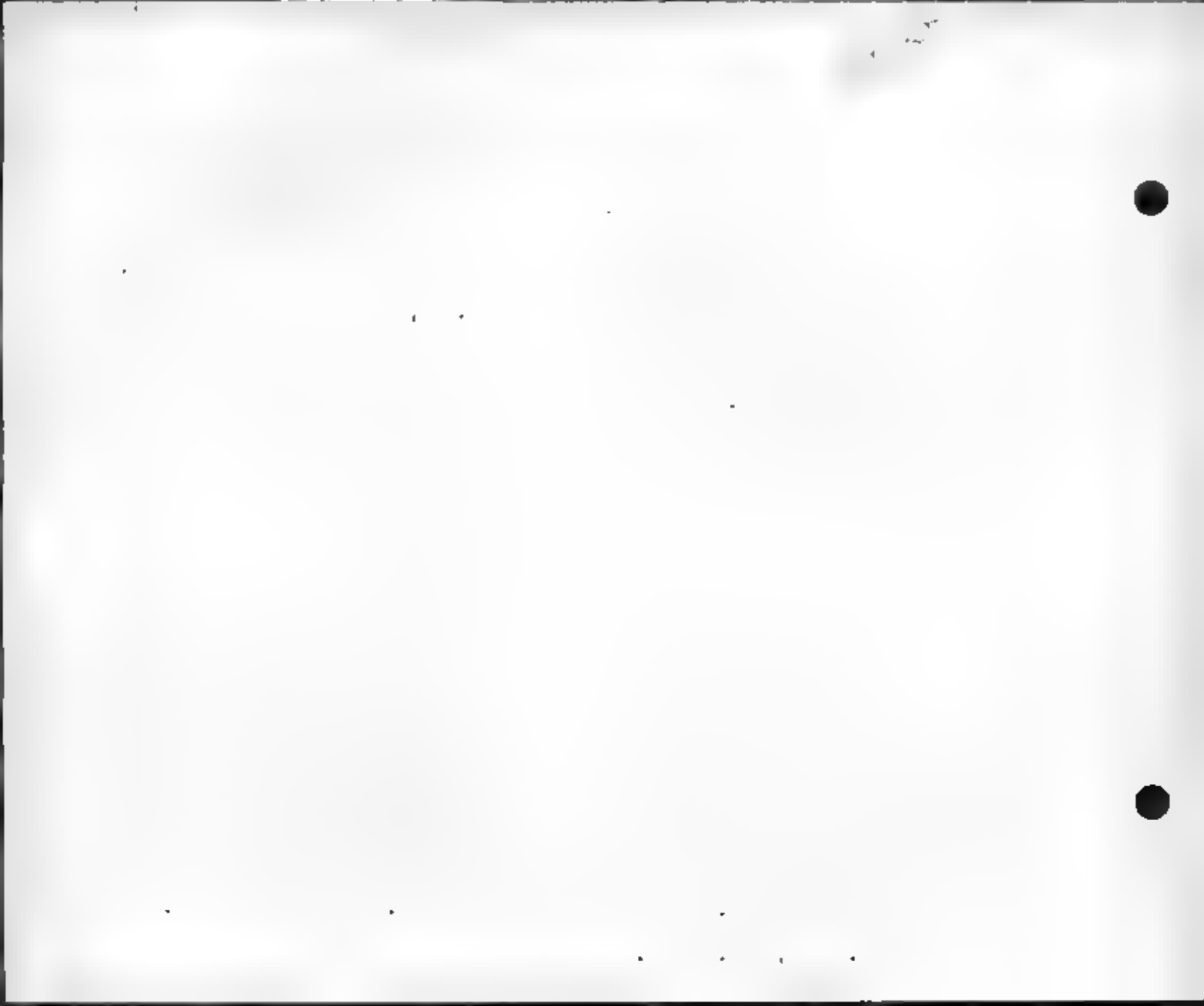


TO DEPUTY MEDICAL EXAMINER. The pathologist should be executed with a 24-hour period. The necessary phase execute the term in the word pending a permit in item 18. Give Pages 2 and 3 of the agenda of item Page 4. It is to be awarded to the Chief Medical Examiner's Office along with the PM3 Request for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7632

PLACE OF DEATH Baltimore		USUAL RESIDENCE Maryland Baltimore	
NAME OF DECEASED LAWSON		BIRTH Baltimore 21294	
NAME OF HOSPITAL St. Joseph's Hospital		ADDRESS 8645 Oakleigh Road	
NAME OF DECEASED JAMES F. BURNS		DATE OF DEATH June 3, 1967	
SEX Male		RACE White	
MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED		DATE OF BIRTH Feb. 26, 1921	
OCCUPATION Asst. Vice President		STATE OF DEATH Maryland	
FATHER'S NAME George L. Burns		MOTHER'S MAIDEN NAME Frances Mumma	
SOCIAL SECURITY NO. 212-18-2739		INFORMANT Mrs. Sue Burns	
CAUSE OF DEATH 4201 Coronary Artery Disease		SIGNATURE <i>[Signature]</i>	
PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/>		DATE SIGNED 6/3/67	
EXAMINER'S NAME CHARLES T. O'DONNELL, M.D.		PLACE OF EXAMINATION Baltimore National Cem.	
DATE OF EXAMINATION 6/6/67		ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



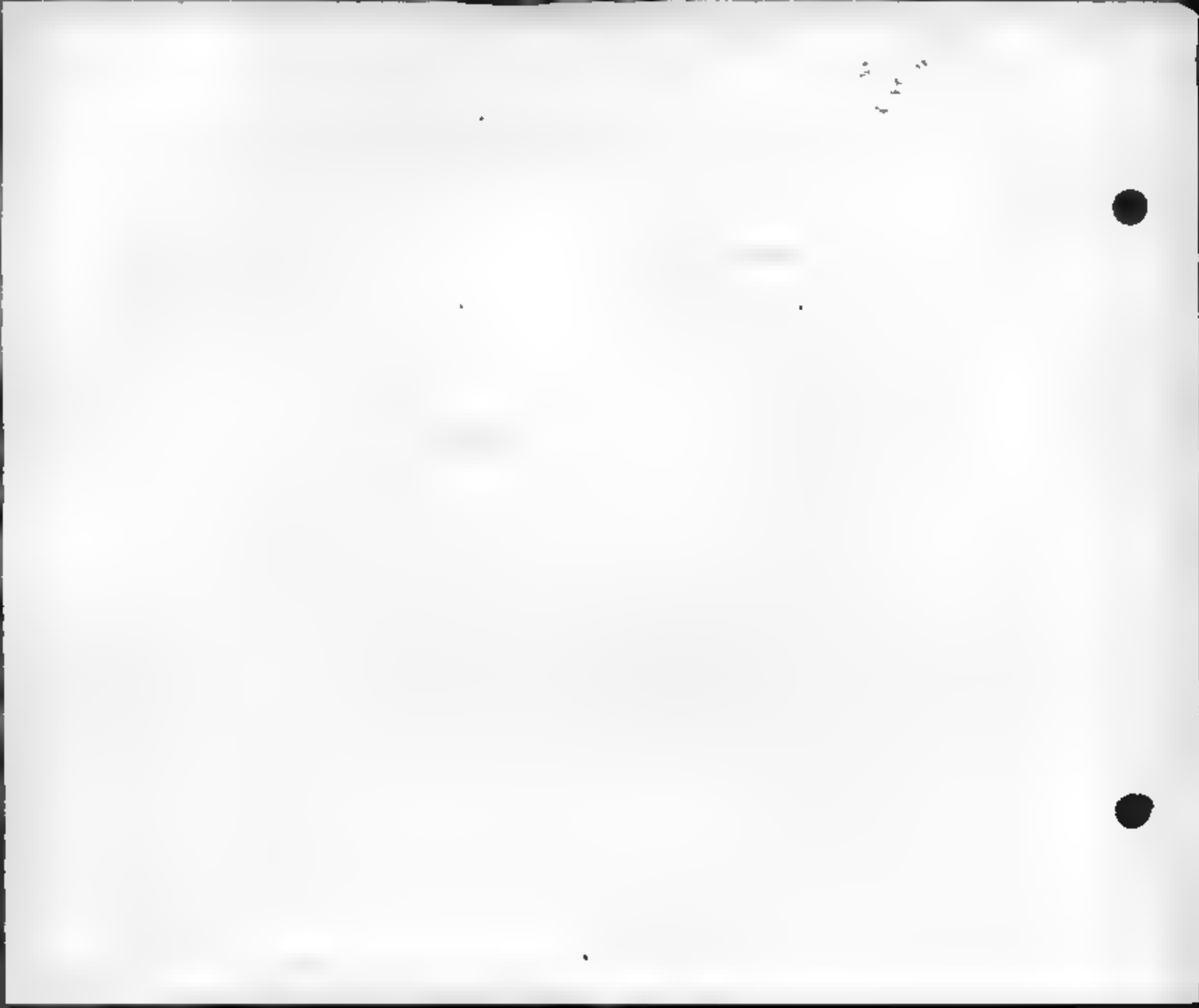
07711

CERTIFICATE OF DEATH

Reg. Dist. No. 07693

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN If outside corporate limits write R.R. and give nearest town Catonsville c. LENGTH OF STAY IN b		2. USUAL RESIDENCE Where deceased lived If institution Residence before admission) a. STATE MD. b. COUNTY	
d. NAME OF HOSPITAL If not in hospital give street address OR IN INSTITUTION Summit Nursing Home		e. STREET ADDRESS 4625 Old Frederick Rd. f. S.F.S. DENISE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED Type or print Joseph A. Burns		4. DATE OF DEATH Month June Day 12 Year 1967	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1892
9a. USUAL OCCUPATION (Give kind of work done) during most of working life even if retired		9b. KIND OF BUSINESS OR INDUSTRY	9c. BIRTHPLACE (State or foreign country) Maryland
10. FATHER'S NAME George Burns		11. MOTHER'S MAIDEN NAME Mary Gillen	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) yes (If yes give unit or dates of service) NW I		13. SOCIAL SECURITY NO. INFORMANT Mrs. Anna M. Burns Address 4625 Old Frederick Rd.	
14. CAUSE OF DEATH Enter only one cause per line (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). heart failure DUE TO (b) myocardial infarction Conditions, if any which gave rise to immediate cause (c), showing the underlying cause (d). long standing DUE TO (c) hypertension PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a			
15. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER (NOT BY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part II at item 16.			
20c. TIME OF INJURY Month 12 Day 12 Year 1967 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY Home farm 20f. (City or town) Baltimore (County) (State)			
21. I certify that I attended the deceased from 12/12/67 to 6/12/67 that I last saw the deceased alive on 6/12/67 and that death occurred at 12 M from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 6/15/67			
ACTUAL SIGNATURE John A. Witke M.D. 5-2-64 PHYSICIAN'S NAME (Type) John A. Witke			
22a. BURIAL CREMATION 22b. DATE THEREOF Burial 6/14/67		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. 22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witke F. D. ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR John A. Witke 24b. REGISTRAR'S SIGNATURE John A. Witke DATE JUN 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician or the funeral director may be retained by the hospital or funeral home to complete and sign the certificate. After this certificate has been signed by the attending physician and completed by the funeral director, the certificate should be detached to use at the burial or cremation. Pages 1 and 2 should be filed with the registrar prior to burial or cremation and in any event within 72 hours after death.



1
2

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. The funeral director should be filed with the State Department of Health prior to burial, cremation or removal, and the original should be filed with the State Department of Health within 72 hours after death.

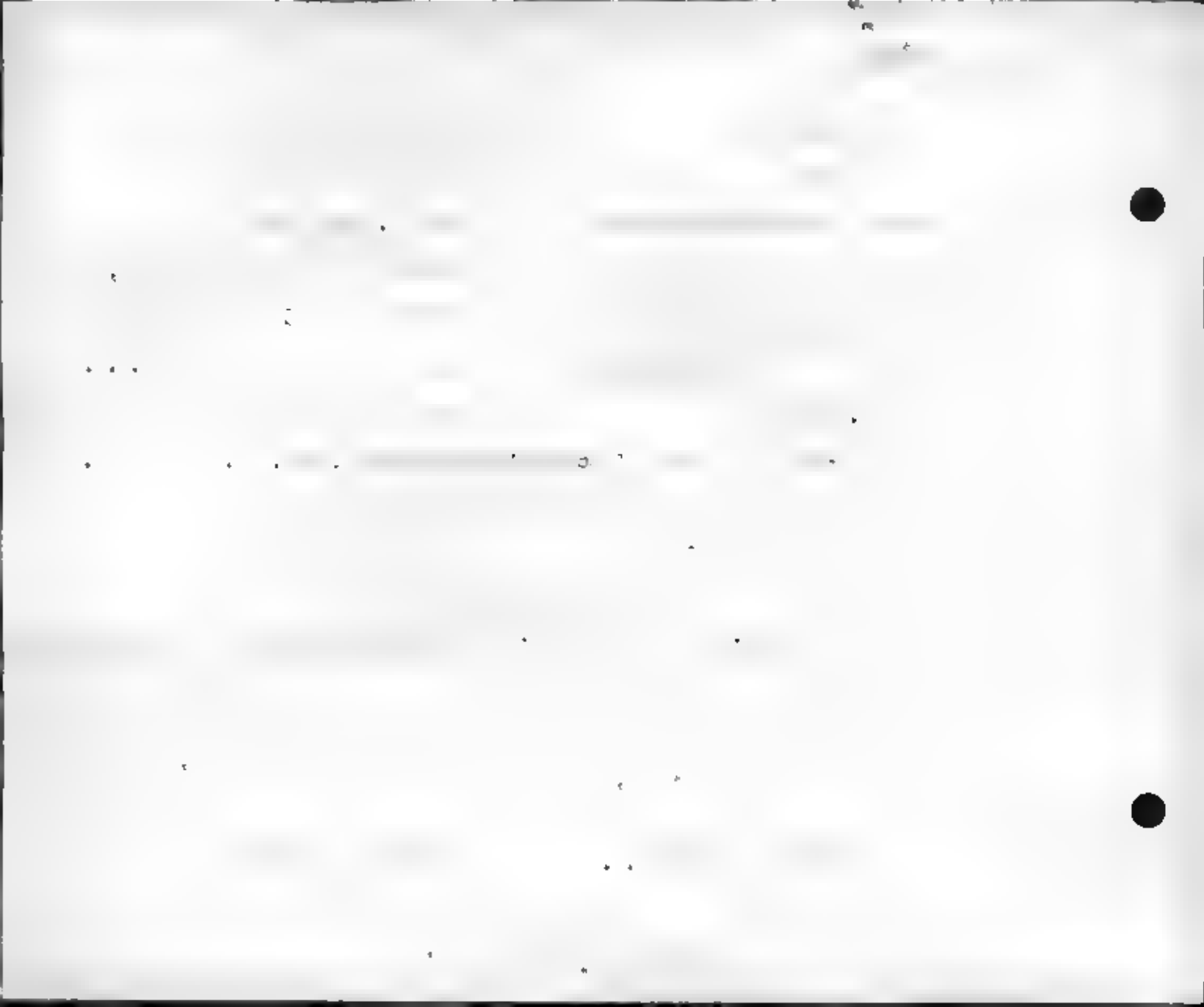
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

07712

CERTIFICATE OF DEATH

07694

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN FORT HOWARD c. LENGTH OF TIME IN 3 DAYS		2. USUAL RESIDENCE (Where deceased lived if different from residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN BALTIMORE	
d. NAME OF HOSPITAL, OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1805 E. 28th STREET	
3. NAME OF DECEASED First Middle Last PHILLIP JAMES CAMPBELL		4. DATE OF DEATH Month Day Year JUNE 10, 1967	
5. SEX MALE 6. COLOR OR RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/28 9. AGE 39 10. IF UNDER 1 YEAR YES 11. IF UNDER 24 HRS NO	
12. OCCUPATION (If not known, state work done during month of death, or even if terminated) PRESSER		13. BIRTHPLACE (State and foreign country) LYNCHBURG, VIRGINIA 14. IF TYPE OF WHAT U.S.A.	
15. FATHER'S NAME JOHN D. CAMPBELL		16. MOTHER'S MARDEN NAME MAGNOLIA JONES	
17. SOCIAL SECURITY NO. 228 22 36 17		18. INFORMANT CLINICAL RECORDS, VAH. FT. HOWARD, MD.	
19. CAUSE OF DEATH (Indicate immediate cause of death) PART 1: DEATH WAS CAUSED BY PNEUMOCOCCAL MENINGITIS 20. IMMEDIATE CAUSE OF DEATH 443 BX 21. DUE TO CONDITIONS (any which have resulted in immediate cause of death) 22. DUE TO PNEUMOCOCCAL PNEUMONIA, LEFT		23. OTHER SIGNIFICANT CONDITION (Indicate if death is NOT RELATED TO THE FATALITY) CHRONIC ALCOHOLISM; DELIRIUM TREMENS; EPILEPSY, IDIOPATHIC.	
24. A. DEATH WAS INTERVENEING B. MURDER C. SUICIDE D. OTHER (Specify)		25. DESCRIBE HOW INJURY OCCURRED (Initial nature of injury, Port of Port of injury, B.)	
26. A. DEATH WAS INTERVENEING B. MURDER C. SUICIDE D. OTHER (Specify)		27. PLACE OF INJURY (Home, School, Work, etc.)	
28. CERTIFY THAT THIS IS A TRUE AND CORRECT STATEMENT OF THE DECEASED June 7, 1967 to June 10, 1967 at 8:00 PM and that death occurred on June 10, 1967		29. SIGNATURE NEILSON NEILSON, M.D. 30. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
31. BURIAL OR CREMATION BURIAL 32. DATE OF BURIAL 6/14/67		33. NAME OF CEMETERY OR REMAINING BALTIMORE NATIONAL CEMETERY, BALTIMORE	
34. FUNERAL DIRECTOR GLOVER FUNERAL HOME		35. BY REGISTERED 1701 PATTERSON PARK AVE. BALTO., MD.	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transcript permit. Then please remove carbon papers. Pages 1 and 2 direct to page 3 should be detached for use as the burial transcript permit. Then please remove carbon papers. Pages 1 and 2 direct to page 3 should be filled with the state Department of Health prior to burial, cremation or removal, and any event, within 72 hours after death.

VR 115-14
25M-16

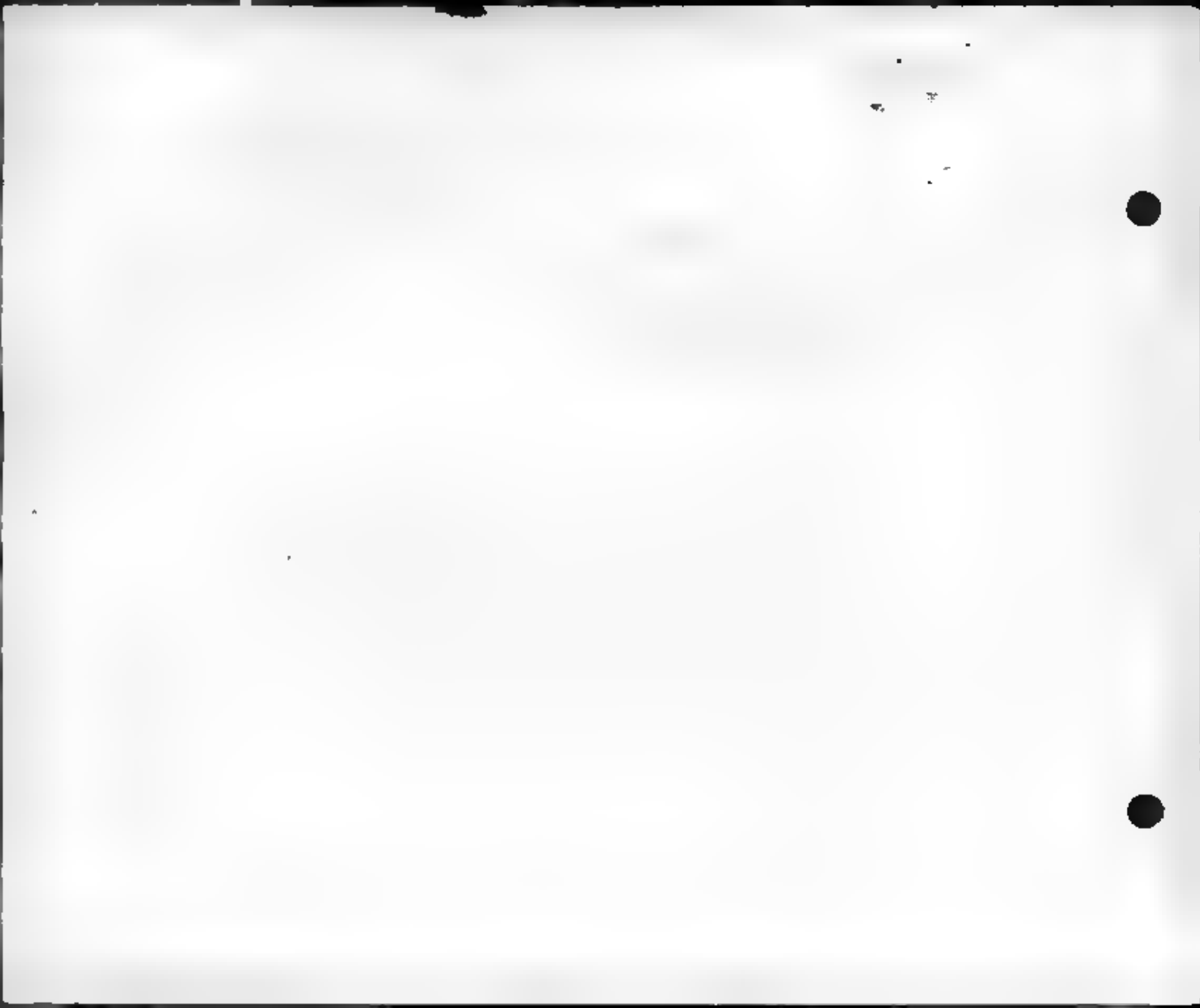
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07715

CERTIFICATE OF DEATH

07635

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. STATE Maryland		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission if not) a. STATE Maryland b. COUNTY Anne Arundle	
3. NAME OF DECEASED First Middle Last Mary White Carswell		4. DATE OF DEATH Month Day Year June 21 1967	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. CITY OF BIRTH 1880 9. AGE (In years last birthday) 87 FUNDING YEAR 1880 MONTHS 10 DAYS 10 HOURS 10 MIN 10	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State or foreign country) Kansas	
12. FATHER'S NAME Mathew White		13. MOTHER'S MAIDEN NAME Martha Underwood	
14. SOCIAL SECURITY NO. Redords: Spring Grove State Hospital		15. INFORMANT Records: Spring Grove State Hospital	
16. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: IMMEDIATE CAUSE Pulmonary Embolism, acute, massive CONDITIONS - any which gave rise to immediate cause, stating the underlying cause Thrombosis, deep pelvic veins, left		INTERVAL BETWEEN ONSET AND DEATH 10 min. 1 day.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I None			
20a. DATE OF BIRTH Month Day Year 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 8) White at work	
21. certify that this hospital attended the deceased from Oct. 1, 1967 to June 21, 1967 and that death occurred on June 21, 1967 from causes and on the date stated above		22. SIGNATURE Anthony J. Young, M.D.	
23a. BURIAL, CREMATION, or other disposition Spring Grove State Hospital		23b. DATE OF DEATH 6-21-67	
24. FUNERAL DIRECTOR Spring Grove State Hospital		25. REGISTRAR'S SIGNATURE DATE JUN 29 1967	



CERTIFICATE OF DEATH

09114

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be data had to use as the burial transit permit. Then please remove carbon papers. Page 1 may be retained by the funeral director.

1. NAME OF DECEASED <i>Allen C. Catherine</i>		2. DATE AND HOUR OF DEATH <i>6/27/67 3A</i>	
3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE WHERE DECEASED LIVED A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i>	
5. FULL NAME OF HOSPITAL OR NURSING HOME <i>RT 1, Box 100A, Luthersville, MD</i>		6. CITY OR TOWN <i>Farmersville, MD</i>	
7. STREET ADDRESS <i>RT 1, Box 100A, Luthersville, MD</i>		8. DATE OF BIRTH <i>10-24-66</i>	
9. SEX <i>M</i>	10. RACE <i>M</i>	11. AGE <i>8</i>	12. C. TITLE OF WHAT COUNTRY? <i>USA</i>
13. USUAL OCCUPATION <i>Student</i>		14. BIRTHPLACE <i>England</i>	
15. FATHER'S NAME <i>James A. Catherine</i>		16. MOTHER'S MARDEN NAME <i>James Catherine</i>	
17. Was Deceased Ever in U. S. Armed Forces? Yes, no or unknown		18. SOCIAL SECURITY NO <i>1-2-2-2-2-2-2-2</i>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>414 967-654 - alien in, street on</i>		20. INTERVAL BETWEEN ONSET AND DEATH <i>causing, but any atresia 8 months</i>	
21. ANTECEDENT CAUSES <i>due to</i>		22. DISEASES OR CONDITIONS if any giving rise to the above cause A. stating the UNDERLYING CONDITION as	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELEVANT TO THE			
24. I certify that I (this hospital) attended the deceased from <i>June 24, 1967 to June 26, 1967</i> and that in my opinion death occurred on the date <i>June 26, 1967</i>			
25. SIGNATURE <i>Allen C. Catherine</i>			
26. PHYSICIAN'S NAME TYPE <i>Allen C. Catherine</i>			
27. DATE SIGNED <i>6/26/67</i>			
28. ADDRESS <i>RT 1, Box 100A, Luthersville, MD</i>			
29. M.D. <i>Allen C. Catherine</i>			
30. BURIAL CREMATION 24B. DATE <i>6-26-67</i>			
31. NAME OF CEMETERY <i>ARMY BOARD OF MARYLAND</i>			
32. NAME OF REGISTRAR <i>UNIVERSITY DISTRICT SCHOOL</i>			
33. ADDRESS <i>UNIVERSITY DISTRICT SCHOOL</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial or cremation or removal and in any event within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201			
CERTIFICATE OF DEATH			
1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town.) c LENGTH OF STAY IN b		2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address.) 622 Fairway Drive		d STREET ADDRESS 622 Fairway Drive	
3 NAME OF DECEASED (Type in print) First Agnes Middle Chenoweth Last Chenoweth		4 DATE OF DEATH Month June Day 10 Year 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 11, 1892
9 AGE in years bIRTHDAY 74		10 IF UNDER 1 YEAR Months 1 Days 24 Hours 4 Minutes 0	
11a ILLNESS OR OPERATION (Give kind of work done during last 14 working days, even if retired) no worker		11b KIND OF BUSINESS OR INDUSTRY London, England	
12 FATHER'S NAME John Donnelly		13 MOTHER'S MAIDEN NAME unknown	
14a Was Deceased EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		14b SOCIAL SECURITY NO. none	
15 INFORMANT J. Keese Chenoweth 622 Fairway Drive Dr. 12		Address	
16 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE to (a) Cardiomyopathy (b) myocardial infarction (c) terminal pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS (ON RIBBON) (DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I) no		17a WAIVER OF BURIAL RIGHTS <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18a AGENT WHO WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER) no		18b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II at item 8)	
19a TIME OF INJURY Month Day Year Hour a.m. 10 p.m. 10		19b INJURY OCCURRED White <input type="checkbox"/> Non White <input type="checkbox"/>	
20a PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20b City town county state	
21 I certify that this hospital attended the deceased from Dec 17, 1965 to 6-10-67 that (1) we last saw the deceased alive on 6-9-67 and that death occurred at 2:00 M. 1 am causes and on the date stated above			
22a SIGNATURE Dr. S. G. Sullivan		22b DATE SIGNED 6-12-67	
22c PHYSICIAN'S NAME (Type) Dr. S. G. Sullivan		22d ADDRESS 1129 St. Paul St.	
23a PERIOD OF MATING Removal Specify 6/13/67		23b DATE THROUGH 6/13/67	
23c NAME OF CEMETERY OR CREMATORY Mount Vernon		23d LOCATION City or town county state Baltimore county, Md.	
24 FUNERAL DIRECTOR Itasca-Wellman Co. Inc. 650 York Rd. Baltimore, Md. 21212		25a RECEIVED BY REGISTRAR JUN 14 1967	
25b REGISTRAR SIGNATURE J. Keese Chenoweth		25c REGISTRAR SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7715

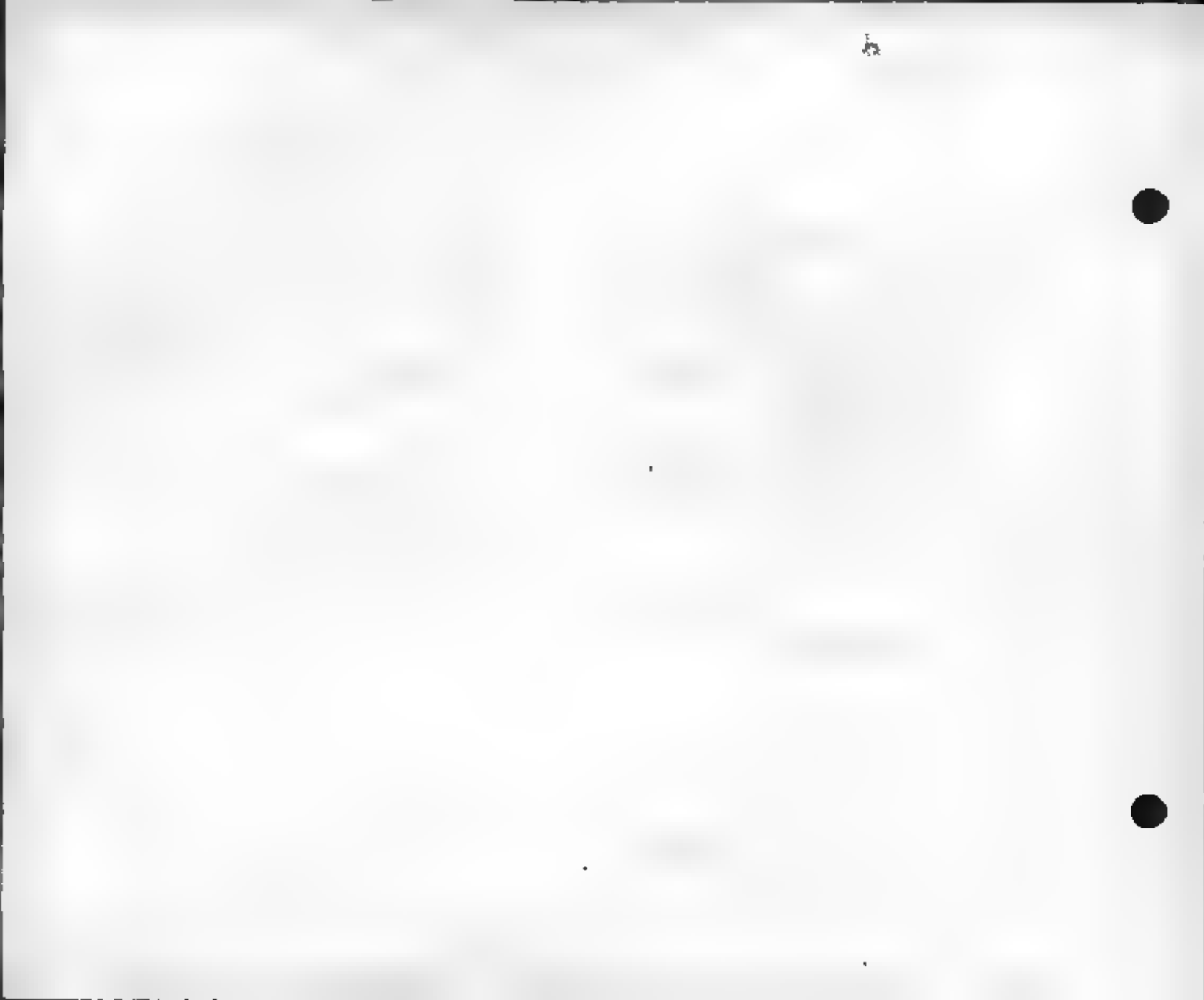
CERTIFICATE OF DEATH

37697

PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL		USUAL RESIDENCE (White deceased lived in institution? Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BROOKLYN PARK d. STREET ADDRESS 525 OLD RIVERSIDE ROAD	
NAME OF DECEASED (Type or print) GEORGE T. CHILDS		4. DATE OF DEATH Month JUNE Day 12 Year 1967	
SEX MALE 6. COLOR OR RACE WHITE MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		b. DATE OF BIRTH JULY 24, 1910 AGE in years for birthday 56 yr.	
10. USUAL OCCUPATION (Give kind of work done or if not at work, to what is he retired) SHEET METAL WORKER		10b. EMPLOYER (If business or profession) PLUMBING COMPANY	
13. FATHER'S NAME HORACE CHILDS		14. MOTHER'S MAIDEN NAME MARY DUMBARTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217 16 17 96	
18. CAUSE OF DEATH (File any one cause per line a, b, or c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE TO HEPATOMA Conditions, if any, which gave rise to immediate cause or, stating the underlying cause lost. BRONCHOPNEUMONIA		19. PLACE OF DEATH CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
20a. INJURY (If injury occurred, describe how, nature of injury in Part II of item 5) 20b. INJURY (If injury occurred, describe how, nature of injury in Part II of item 5) 20c. PLACE OF INJURY (Home, farm, factory, street, office, lodging, etc.) 20d. CITY OR TOWN 20e. STATE		21. I certify that this is a true and correct copy of the death record as shown to me on 6/12/67 and that the death occurred on 6/12/67 at 8:30A M from causes and on the date stated above.	
22a. SIGNATURE JOHN D. TALBERT, M. D.		22b. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE WHEN June 15, 1967	
24. FUNERAL DIRECTOR George J. Gonce		25. PLACE OF BURIAL OR CREMATION BALTIMORE NATIONAL 26. CITY OR TOWN BALTIMORE, MARYLAND 27. DATE JUN 15 1967 28. SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital as a attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be detached or use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the Division of Vital Records. The law requires that the death certificate be executed within 24 hours after death.

VR 415 (4)
25M 1/67



07716

CERTIFICATE OF DEATH

07698

1. PLACE OF DEATH a. <u>Baltimore</u> b. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town." <u>Randallstown</u> c. NAME OF HOSPITAL OR INSTITUTION "If not in hospital, give street address." <u>Baltimore County General</u>		2. USUAL RESIDENCE "Where deceased lived if invalid on Residence before admission." a. STATE <u>Maryland</u> b. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town." <u>Baltimore</u> c. STREET ADDRESS <u>3411 Rolling Road</u> d. IS RESIDENCE ON A ARMY VE <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Type in full First Middle Last <u>Sophia Immeleusk</u>		4. DATE OF DEATH Month Day Year <u>6 7 1967</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/87</u>
9. AGED "In years as birthday." <u>80</u>		10. FINDER YEAR Months Days Hours M. <u>8 7 1967</u>	
11. OCCUPATION "Give kind of work done during most of working life ever it is paid." <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13. BIRTHPLACE (County & State or foreign country) <u>POLAND</u>		14. "IN OF WHAT COUNTRY?" <u>U.S.A</u>	
15. FATHER'S NAME <u>MARCELLINE SOSNOWSKI</u>		16. MOTHER'S MAIDEN NAME <u>FRANCES SZYNKIEWICZ</u>	
17. Was deceased ever in U.S. Armed Forces? Yes, no or unknown (If yes, give war or dates of service) <u>NO</u>		18. SOCIAL SECURITY NO <u>NO</u>	
19. INFORMANT <u>JOHN SOSNOWSKI</u>		Address <u>3411 N ROLLING RD 21207</u>	
B. CAUSE OF DEATH "Enter only one cause per line for a, b, and c." PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4200 DUE TO (b) <u>Arteriosclerotic Vascular Heart Disease</u> and/or any which gave rise to a medical cause of death (c) <u>Dissection</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item B)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>9</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY Home farm, factory, street, office, bldg, etc.	20f. (City or town) County (State)
21. I certify that (this hospital) attended the deceased from <u>5-7-67</u> 19 <u>67</u> to <u>6-7</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6-7</u> 19 <u>67</u> and that death occurred at <u>11 A</u> M from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>6-7-67</u>	
22c. PHYSICIAN'S NAME Type <u>BALTO COUNTY GEN HOSP</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-10-67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR REMATORY <u>HOLY CROSS CEM</u>	23d. LOCATION City or Town County (State) <u>ANNE ARUNDEL Co MD</u>
24. FUNERAL DIRECTOR <u>W. Fialkowski</u>		25a. REF ID BY REGISTRAR <u>DALE N 9</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
26. ADDRESS <u>2007 EASTERN AVE</u>		27. CITY, STATE, ZIP <u>BALTO MD 21291</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please detach page 3 and send it to the funeral home. Page 3 should be detached for use as the burial-transit permit. Then please return page 4 to the funeral home. This certificate should be filed with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

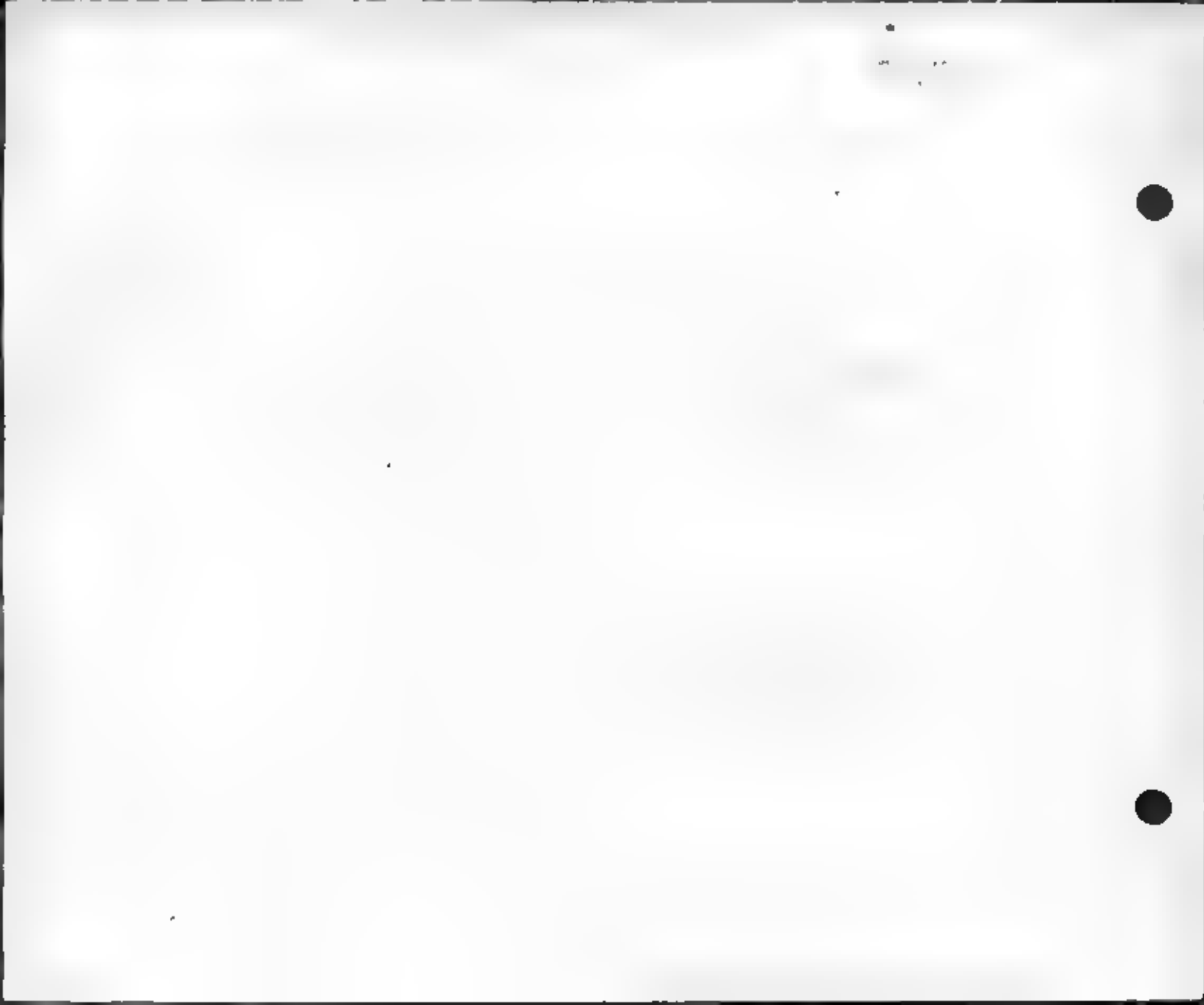
07717

CERTIFICATE OF DEATH

07699

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN Towson		c. LENGTH OF STAY IN TS 2 days		d. CITY OR TOWN Towson Md. 21204	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		f. STREET ADDRESS 8110 Hillendale Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) Maria Angelina Cicero (OR Angeline Maria Cicero)		4. DATE OF DEATH Month June Day 6 Year 1967		5. AGE in years last birthday 79 yrs	
6. SEX F.		7. COLOR OR RACE W.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY At Home		10. BIRTHPLACE (County & State or foreign country) Italy	
11. FATHER'S NAME Nunzio Maranto		12. MOTHER'S MAIDEN NAME Unknown			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. JOURNAL OF DEATH NO		15. INFORMANT Hosp. Rec.	
16. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a. Acute Myocardial Infarction 1b. Conditions if any, which gave rise to immediate cause a stating the underlying cause last 1c. 1a 1d. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1a, 1b, and 1c.					INTERVAL BETWEEN ONSET AND DEATH
20a. ACT DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOT IFF MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 20a or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY Home Farm Factory street office bldg. etc.	
20f. (City or town)		20g. (County)		20h. (State)	
2. I certify that the hospital attended the deceased from June 4, 1967 to June 6, 1967 that we last saw the deceased alive on June 6, 1967 and that death occurred at 8:10 P.M.					
21a. SIGNATURE Dr. Gracito		21b. DATE SIGNED June 6, 1967		21c. PHYSICIAN'S NAME (Type) Dr. Gracito Patricio	
21d. ADDRESS St. Josephs Hospital		21e. DATE BY REGISTRAR June 9 1967			
21f. REGISTRAR'S SIGNATURE Charles Judge		21g. REGISTRAR'S NAME Charles Judge			
22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		22b. DATE THEREOF June 9, 1967		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	
22d. CITY OR TOWN Baltimore, Md.		22e. (County)		22f. (State)	
23. FUNERAL DIRECTOR Vernon Lemmon 4611 Park Heights Av. Balto.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove or destroy pages 1 and 2. This should be filed in the State Dept of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

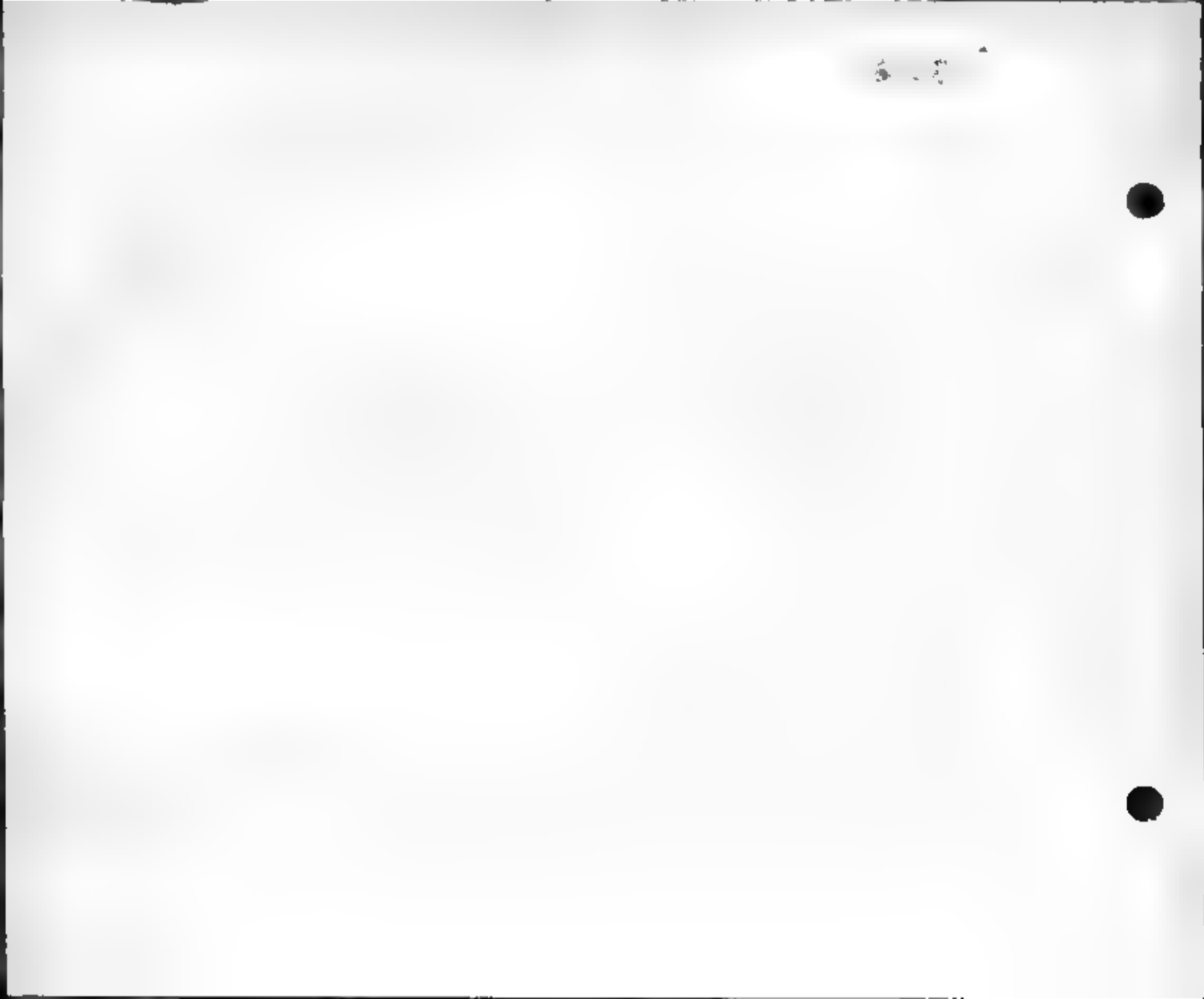
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07718

07760

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month
Robert	Edward	Clark	John	June	17
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE in years (last birthday)	Month
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 18, 1901	7	17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Clerk		Varied		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Robert Clark		Mary Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Name, Address, Relationship)	
0		217-16-08561		John Clark, 07 Maryland Ave., Baltimore	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal failure</u>					
DUE TO (b) <u>Congestive heart failure</u>					
DUE TO (c) <u></u>					
PART II OTHERS' SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 5, 1967</u> to <u>JUNE 17, 1967</u> that (I) <u>last</u> saw the deceased alive on <u>JUNE 11, 1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE		22b. DATE SIGNED			
<u>W. K. Hall</u>		13 June 67			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
<u>W. K. Hall</u>		<u>6601 N. W. 1st St. E. 1122 228</u>			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		June 20, 1967		Mt. Olive	
24. FUNERAL DIRECTOR		25a. REC'D BY REG. STRAR		25b. REG. STRAR'S SIGNATURE	
<u>STEWART & MOWEN CO., 108 W. North Av., Balto.</u>		DATE <u>JUN 21 1967</u>		<u>W. K. Hall</u>	



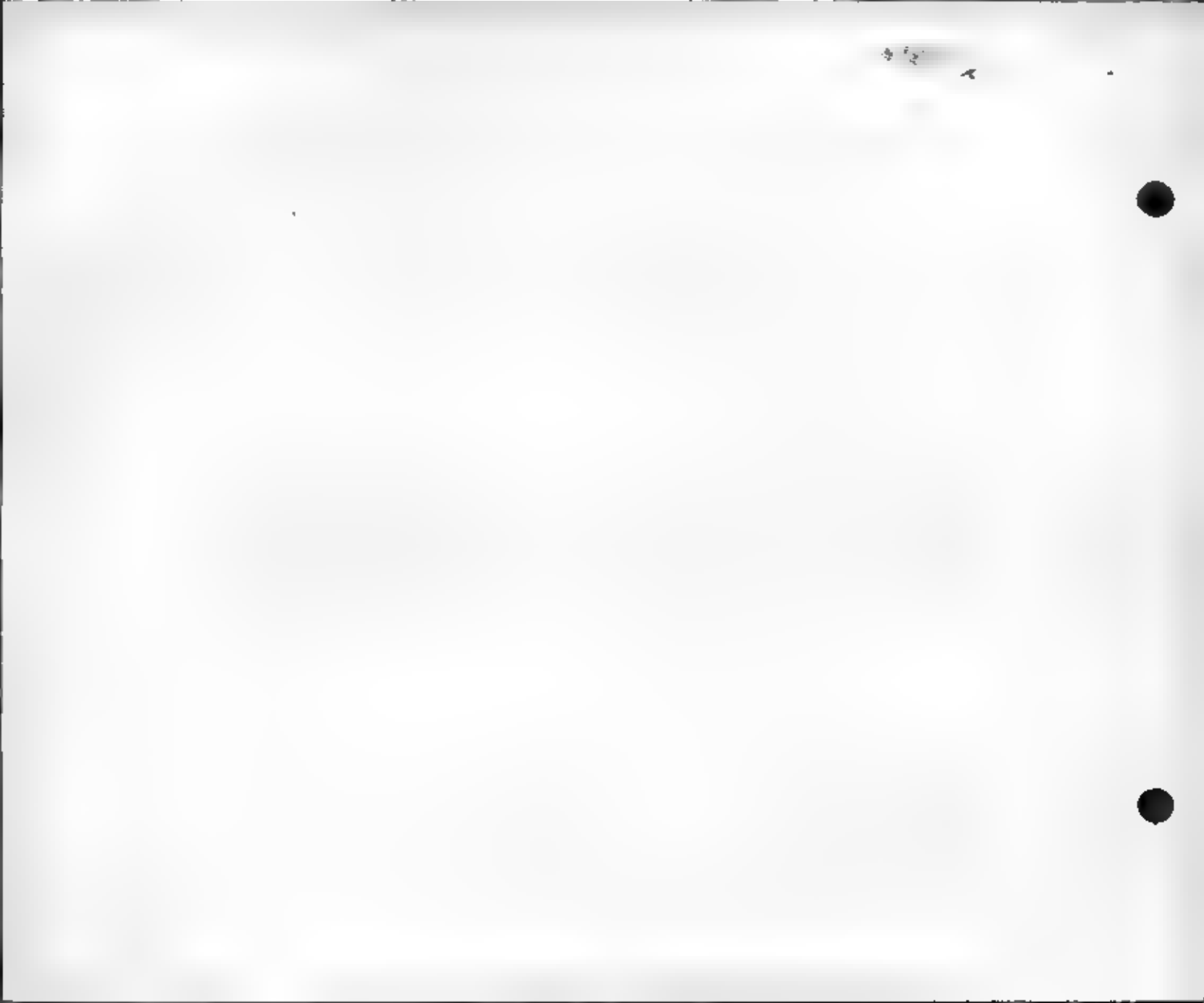
07713

CERTIFICATE OF DEATH

07701

1 PLACE OF DEATH a COUNTY BALTO b CITY OR TOWN If outside corporate limits with RURAL and give nearest town Randallstown c NAME of hospital or institution ON If not a hospital give street address BALTO COUNTY GENERAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution Resident before admission) a STATE MD b COUNTY BALTO c CITY OR TOWN If outside corporate limits with RURAL and give nearest town BALTO	
3 NAME OF DECEASED (Type in print) First MEYER Middle MI Last COHEN		4 DATE OF DEATH Month 6 Day 6 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month 7 Day 6 Year 1967
10a USUAL OCCUPATION Give kind of work done during last week or last season (include training) Manager		10b KIND OF BUSINESS OR INDUSTRY Clothing	11 BIRTHPLACE (Country & State or foreign country) MARYLAND
12 FATHER'S NAME HARRIS COHEN		13 MOTHER'S NAME JEAN RICHTER	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) 2/13-08-1963		15 SOCIAL SECURITY NO. 213-08-1613	
16 CAUSE OF DEATH (Enter only one cause per part. Death was caused by IMMEDIATE CAUSE (a) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), showing the underlying cause (b) 17 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19 CAUSE OF DEATH (Enter only one cause per part. Death was caused by IMMEDIATE CAUSE (a) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), showing the underlying cause (b) ACUTE MYOCARDIAL INFARCTION 5 HRS	
20a IDENTIFY WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
21a TIME OF INJURY Month Day Year Hour 19 PM	21b INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21c PLAC. OF INJURY (Home, farm, factory, street, other bldg. etc.)	21d CITY or town (County) (State)
2 I certify that (1) this hospital attended the deceased from 6-6-67 , 19 66-67 to 6-6-67 , 19 66-67 that (1) (we) last saw the deceased alive on 6-6 , 19 67 and that death occurred 6-6 M, from causes and on the date stated above.			
22a SIGNATURE Dr. Samuel Tomjakov		22b DATE SIGNED 6/6/67	
23a PHYSICIAN'S NAME (Type) SAMUEL TOMJAKOV		23b ADDRESS BALTO. COUNTY HOSPITAL	
24a BURIAL INFORMATION REMOVED (Specify) BALTO.	24b DATE THEREOF 6/8/67	24c NAME OF CEMETERY OR CREMATORY BETH ISRAEL	24d LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND
25a REGD BY REGISTRAR SOL LEVINSON & GROS. INC., 6010 REIST., RD.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, with a 24-hour notice of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07720

07702

PLACE OF DEATH
a. COUNTY

BALTIMORE

MARYLAND

2 USUAL RESIDENCE Where deceased lived if institution; Residence before admission:

a. STATE

b. COUNTY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY in 1b

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BALTIMORE

BALTIMORE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

d. STREET ADDRESS

3512 LANCREAR ROAD

3512 LANCREAR ROAD

3 NAME OF DECEASED (Type or print)

First Middle Last

DATE OF DEATH

Month

Day

4 5 RESIDENCE ON A FARM: YES ☐ NO ☐

5 SEX

6 COLOR OR RACE

RAY

COHEN

(HEALEY)

8 DATE OF BIRTH

9 AGE (in years last birthday)

10 UNDER 24 HRS IF UNDER 24 HRS

FEMALE

WHITE

WIDOWED ☒

DIVORCED ☐

AUG. 8, 1891

75

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

10b. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE County & State or foreign country

12 CITIZEN OF WHAT COUNTRY?

HOUSEWIFE

AT HOME

BALTIMORE, MARYLAND

USA

13 FATHER'S NAME

4 MOTHER'S MAIDEN NAME

UNKNOWN

UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of date of service)

16 SOCIAL SECURITY NO. 17 INFORMANT

Address

18. CAUSE OF DEATH Enter only one cause per line for a, b, and c.

MS. INFLUENZA, SICKER, 3302 TILLS' LANE, REAL

INTERVAL BETWEEN ONSET AND DEATH

PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions if any which gave rise to immediate cause or stating the underlying cause first.

(b) DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS A JEOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? If other, notify medical examiner

20b DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part (a) or Part II of item 18.

20c TIME OF INJURY Month Day Year Hour a.m. p.m.

20d INJURY OCCURRED White Not White at work ☐ at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town)

(County)

(State)

21 I certify that (1) this hospital attended the deceased from 1956 to 1967 and that death occurred at 7 PM from the causes and on the date stated above

22a SIGNATURE

ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type or print)

22d ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify)

6/21/67

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION City town or county

(State)

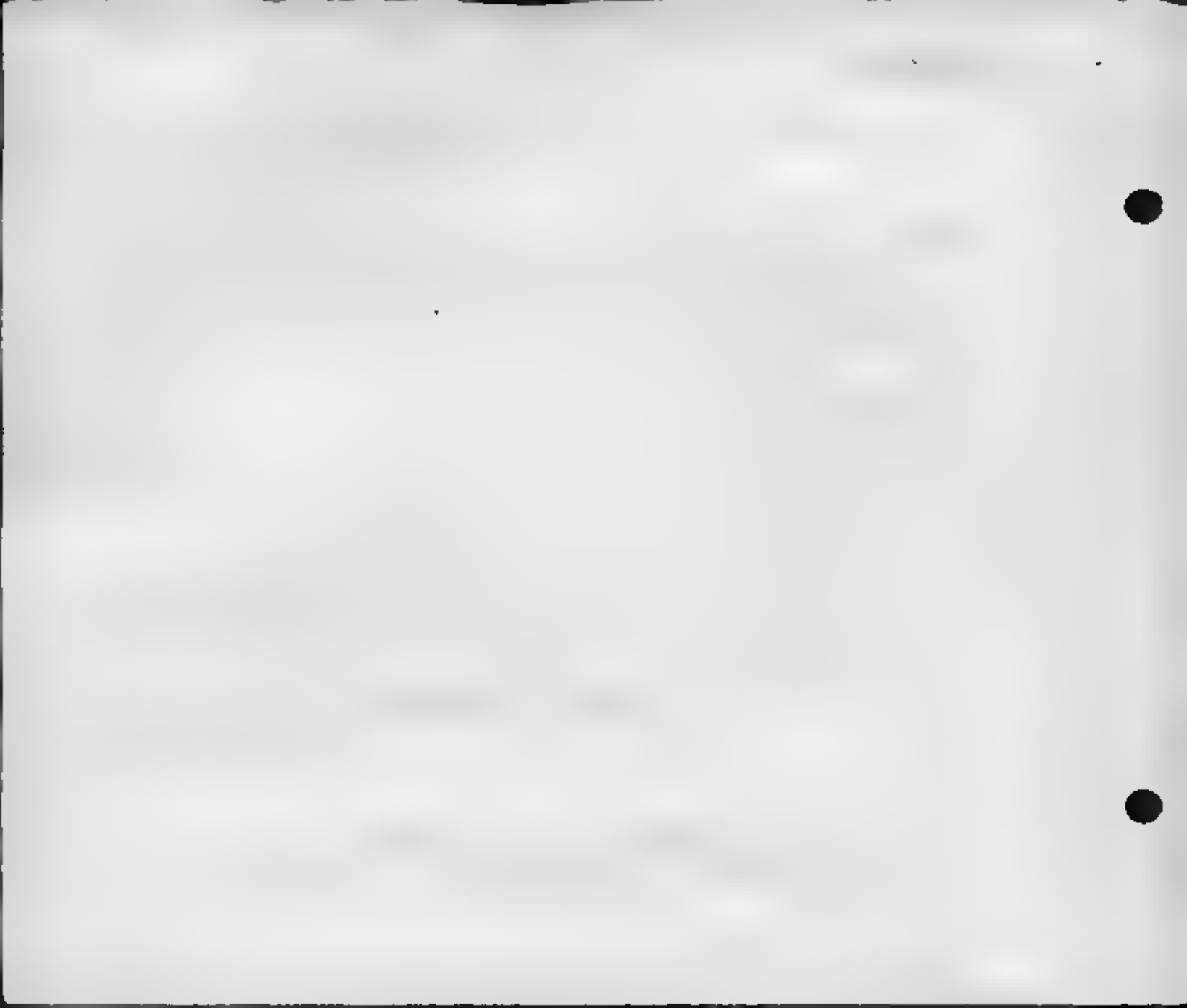
24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE

SOL LEVITSKY & BROS. INC., 6010 REIST, RD.

DATE JUN 23 1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07703

FOR STATE HEALTH DEPT.

07721

PLACE OF DEATH

ELI T. MOORE COUNTY

at 964

MARK ONE

LENGTH OF STAY IN B

SPARROWS POINT

NAME, ADDRESS, AND PHONE NUMBER OF PLACE WHERE DEATH OCCURRED

SS BETH TEX

USUAL RESIDENCE OF DECEASED

Maryland

Baltimore

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore - Dundalk

1938 Eastfield Road

3 NAME OF DECEASED

First Middle Last

MARINUS

COLDIKE

4 DATE OF DEATH

Month

Day

Year

June

25

1967

SEX

MALE

WIDOWED

MARRIED

SINGLE

DATE OF BIRTH

1/26/05

AGE

62

MONTHS

YEARS

DAYS

HOURS

MINUTES

Male

White

10. USUAL OCCUPATION (Give kind of work done)

Merchant Seaman

11. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co. Holland

12. BIRTHPLACE (State or foreign country)

13. COUNTRY OF BIRTH

U. S. A.

13. FATHER'S NAME

Sikke Koldyk

14. MOTHER'S MAIDEN NAME

Antje Weyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL SECURITY NO.

180-12-3686

17. INFORMANT (Name)

Mrs. Katherine Coldike, 1938 Eastfield Rd.

Address

18. CAUSE OF DEATH

PART DEATH WAS CAUSED BY

NAME (List all)

Arteriosclerotic Heart Disease

DUE TO

(b)

DUE TO

Conditions (if any) which gave rise to immediate cause or, stating the underlying cause

19. OTHER SIGNIFICANT INFORMATION CONCERNING DEATH (e.g., not reported, the person was in part)

20. PRIMARY OR CONTRIBUTING CAUSE OF DEATH

21. DESCRIBE HOW INJURY OCCURRED (e.g., fall, fire, etc.)

22. INJURY

23. DEATH

24. TIME

25. PLACE

26. DATE

27. TIME

28. PLACE

29. DATE

30. TIME

31. PLACE

32. DATE

33. TIME

34. PLACE

35. DATE

36. TIME

37. PLACE

38. DATE

39. TIME

40. PLACE

41. DATE

42. TIME

43. PLACE

44. DATE

45. TIME

46. PLACE

47. DATE

48. TIME

49. PLACE

50. DATE

I certify that each charge of the manner described above is true and correct and in my opinion death resulted from

Major cause

Accident

Suicide

Heart failure

In terminal condition

ACTUAL SIGNATURE

EXAMINER'S NAME

Russell S. Fisher, M.D.

HIEF MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

DEPUTY MED. A. EXAMINER

23. LOCATION (City or town)

Baltimore, Md.

24. BURIAL REMOTION

Burial

25. DATE

7/1/67

26. PLACE

Oak Lawn Cemetery

27. INHUMATION

28. ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md.

29. REC'D BY REG. CLERK

DATE

JUL 3 1967

30. REC'D BY REG. CLERK

DATE

JUL 3 1967

22 DATE SIGNED

June 28, 1967

TO DEPUTY MEDICAL EXAMINER This certificate should be executed with in 24 hours of the death and 3 to 5 days after the death of the deceased. The word pending in pencil in item 18-Give Pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3 Page 1.

TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

228 44664



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07722

CERTIFICATE OF DEATH

07704

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Catonsville		2 USUAL RESIDENCE (Where deceased lived at institution. Residence before admission) a STATE Maryland b COUNTY Prince George's c CITY OR TOWN West Hyattsville, Maryland	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSPITAL		d STREET ADDRESS 6421 Sargent Road	
4 NAME OF DECEASED First Julia Middle Coleman Last Coleman		5 DATE OF DEATH Month June Day 25 Year 1967	
6 SEX female	7 COLOR OR RACE white	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE In years 89 Month March Day 22 Year 1878
10a OCCUPATION Give kind of work done during most of working life, even if retired housewife		10b KIND OF BUSINESS OR INDUSTRY Penna.	
11 FATHER'S NAME George Anderson		12 MOTHER'S MARRIED NAME Anna Wiles	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> (If yes give war and dates of service)		14 SOCIAL SECURITY NO. 219-54-3076	
15 BIRTHPLACE (County & State of Inheritance) Penna.		16 CITIZENSHIP OF WHAT COUNTRY? U. S.	
17 BIRTHPLACE (County & State of Inheritance) Penna.		18 CITIZENSHIP OF WHAT COUNTRY? U. S.	
19 BIRTHPLACE (County & State of Inheritance) Penna.		20 CITIZENSHIP OF WHAT COUNTRY? U. S.	
21 BIRTHPLACE (County & State of Inheritance) Penna.		22 CITIZENSHIP OF WHAT COUNTRY? U. S.	
23 BIRTHPLACE (County & State of Inheritance) Penna.		24 CITIZENSHIP OF WHAT COUNTRY? U. S.	
25 BIRTHPLACE (County & State of Inheritance) Penna.		26 CITIZENSHIP OF WHAT COUNTRY? U. S.	
27 BIRTHPLACE (County & State of Inheritance) Penna.		28 CITIZENSHIP OF WHAT COUNTRY? U. S.	
29 BIRTHPLACE (County & State of Inheritance) Penna.		30 CITIZENSHIP OF WHAT COUNTRY? U. S.	
31 BIRTHPLACE (County & State of Inheritance) Penna.		32 CITIZENSHIP OF WHAT COUNTRY? U. S.	
33 BIRTHPLACE (County & State of Inheritance) Penna.		34 CITIZENSHIP OF WHAT COUNTRY? U. S.	
35 BIRTHPLACE (County & State of Inheritance) Penna.		36 CITIZENSHIP OF WHAT COUNTRY? U. S.	
37 BIRTHPLACE (County & State of Inheritance) Penna.		38 CITIZENSHIP OF WHAT COUNTRY? U. S.	
39 BIRTHPLACE (County & State of Inheritance) Penna.		40 CITIZENSHIP OF WHAT COUNTRY? U. S.	
41 BIRTHPLACE (County & State of Inheritance) Penna.		42 CITIZENSHIP OF WHAT COUNTRY? U. S.	
43 BIRTHPLACE (County & State of Inheritance) Penna.		44 CITIZENSHIP OF WHAT COUNTRY? U. S.	
45 BIRTHPLACE (County & State of Inheritance) Penna.		46 CITIZENSHIP OF WHAT COUNTRY? U. S.	
47 BIRTHPLACE (County & State of Inheritance) Penna.		48 CITIZENSHIP OF WHAT COUNTRY? U. S.	
49 BIRTHPLACE (County & State of Inheritance) Penna.		50 CITIZENSHIP OF WHAT COUNTRY? U. S.	
51 BIRTHPLACE (County & State of Inheritance) Penna.		52 CITIZENSHIP OF WHAT COUNTRY? U. S.	
53 BIRTHPLACE (County & State of Inheritance) Penna.		54 CITIZENSHIP OF WHAT COUNTRY? U. S.	
55 BIRTHPLACE (County & State of Inheritance) Penna.		56 CITIZENSHIP OF WHAT COUNTRY? U. S.	
57 BIRTHPLACE (County & State of Inheritance) Penna.		58 CITIZENSHIP OF WHAT COUNTRY? U. S.	
59 BIRTHPLACE (County & State of Inheritance) Penna.		60 CITIZENSHIP OF WHAT COUNTRY? U. S.	
61 BIRTHPLACE (County & State of Inheritance) Penna.		62 CITIZENSHIP OF WHAT COUNTRY? U. S.	
63 BIRTHPLACE (County & State of Inheritance) Penna.		64 CITIZENSHIP OF WHAT COUNTRY? U. S.	
65 BIRTHPLACE (County & State of Inheritance) Penna.		66 CITIZENSHIP OF WHAT COUNTRY? U. S.	
67 BIRTHPLACE (County & State of Inheritance) Penna.		68 CITIZENSHIP OF WHAT COUNTRY? U. S.	
69 BIRTHPLACE (County & State of Inheritance) Penna.		70 CITIZENSHIP OF WHAT COUNTRY? U. S.	
71 BIRTHPLACE (County & State of Inheritance) Penna.		72 CITIZENSHIP OF WHAT COUNTRY? U. S.	
73 BIRTHPLACE (County & State of Inheritance) Penna.		74 CITIZENSHIP OF WHAT COUNTRY? U. S.	
75 BIRTHPLACE (County & State of Inheritance) Penna.		76 CITIZENSHIP OF WHAT COUNTRY? U. S.	
77 BIRTHPLACE (County & State of Inheritance) Penna.		78 CITIZENSHIP OF WHAT COUNTRY? U. S.	
79 BIRTHPLACE (County & State of Inheritance) Penna.		80 CITIZENSHIP OF WHAT COUNTRY? U. S.	
81 BIRTHPLACE (County & State of Inheritance) Penna.		82 CITIZENSHIP OF WHAT COUNTRY? U. S.	
83 BIRTHPLACE (County & State of Inheritance) Penna.		84 CITIZENSHIP OF WHAT COUNTRY? U. S.	
85 BIRTHPLACE (County & State of Inheritance) Penna.		86 CITIZENSHIP OF WHAT COUNTRY? U. S.	
87 BIRTHPLACE (County & State of Inheritance) Penna.		88 CITIZENSHIP OF WHAT COUNTRY? U. S.	
89 BIRTHPLACE (County & State of Inheritance) Penna.		90 CITIZENSHIP OF WHAT COUNTRY? U. S.	
91 BIRTHPLACE (County & State of Inheritance) Penna.		92 CITIZENSHIP OF WHAT COUNTRY? U. S.	
93 BIRTHPLACE (County & State of Inheritance) Penna.		94 CITIZENSHIP OF WHAT COUNTRY? U. S.	
95 BIRTHPLACE (County & State of Inheritance) Penna.		96 CITIZENSHIP OF WHAT COUNTRY? U. S.	
97 BIRTHPLACE (County & State of Inheritance) Penna.		98 CITIZENSHIP OF WHAT COUNTRY? U. S.	
99 BIRTHPLACE (County & State of Inheritance) Penna.		100 CITIZENSHIP OF WHAT COUNTRY? U. S.	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FLUNERAL DIRECTOR & to this certificate has been signed by the attending physician and completed by the funeral director. Page 4 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove a page and place it in the State Dept. of Health for filing. Page 2 should be filed with the State Dept. of Health for filing. Page 1 should be filed with the State Dept. of Health for filing.

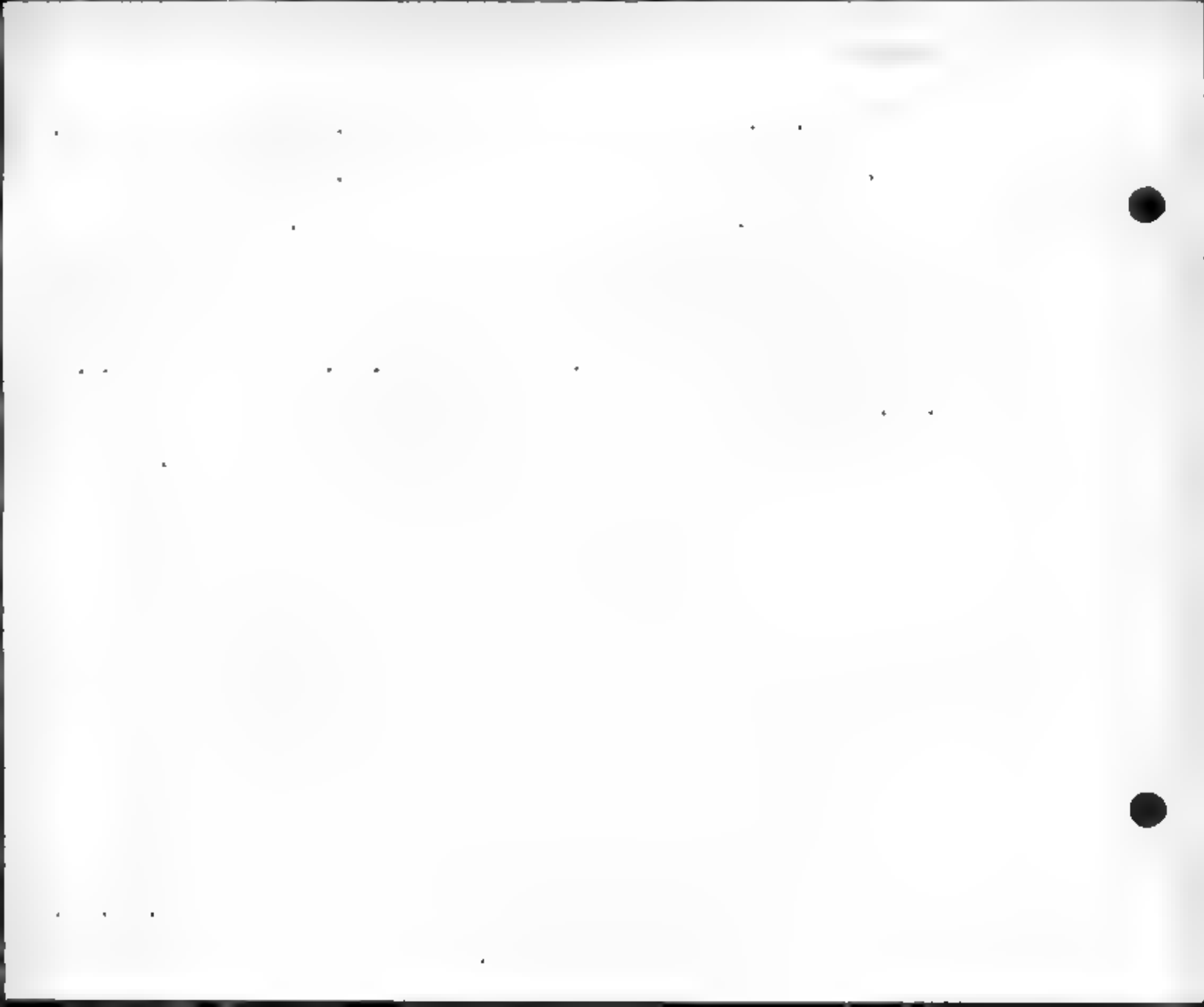
24 FUNERAL DIRECTOR
Wm. J. Jackson & Sons with Inc.
25a REG. BY REGISTRAR
JUN 30 1967
25b REGISTRAR'S SIGNATURE
Charles Judge



92205

TO ■■■ SPITAL OR ATTENDING PHYSICIAN ■■■ The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO ■■■ FUNERAL DIRECTOR ■■■ After his certificate has been signed by the attending physician and completely filled in by the time a date or page 3 should be dated for use as the burial transit permit. Then please remove carbon papers (page 1 and 2) should be filed with the State Dept. of Health prior to burial. Cremation or removal and subsequent death should be filed with the State Dept. of Health prior to cremation and subsequent death within 72 hours after death.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Divison of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77724

77706

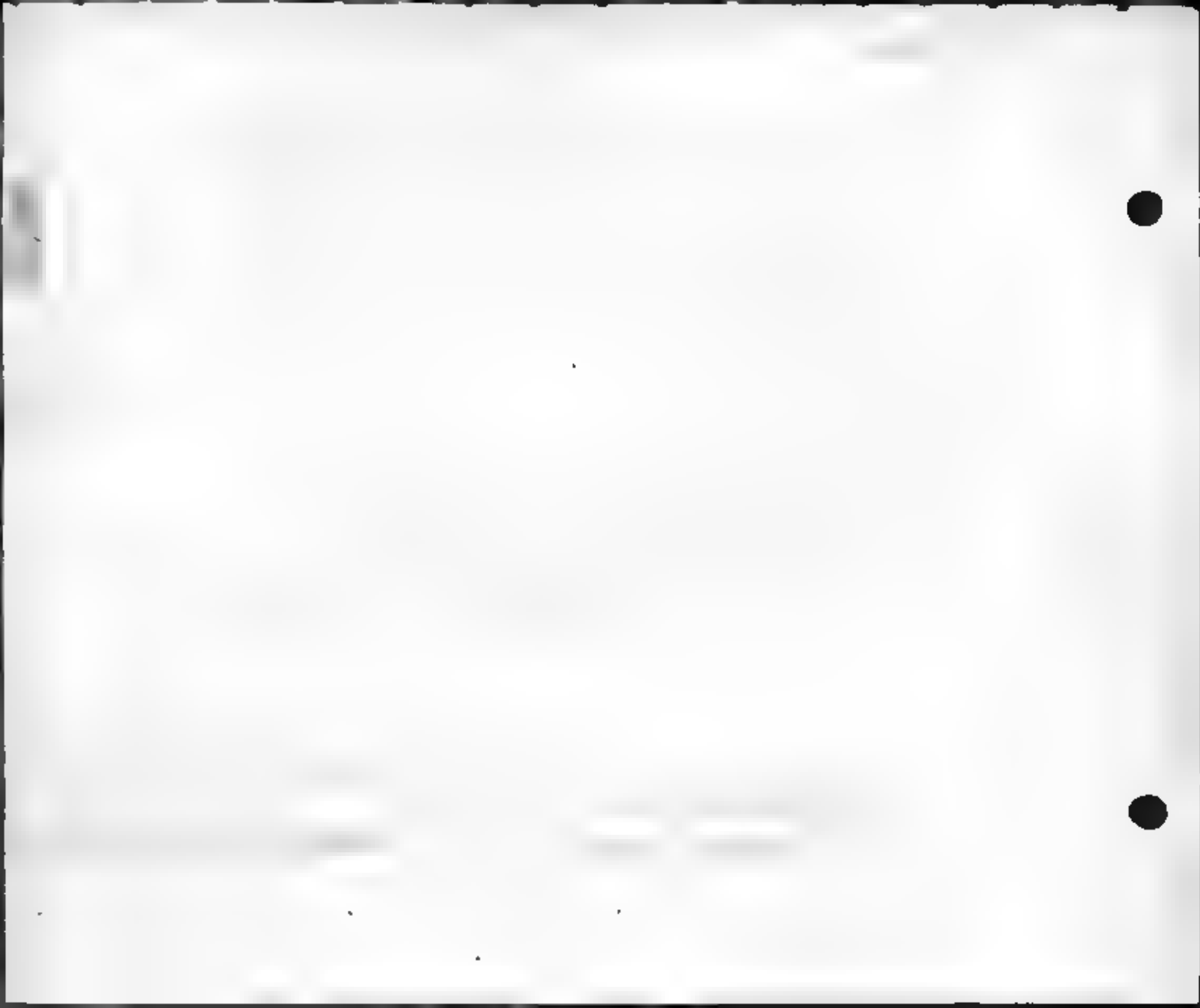
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural White Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural White Hall	
c. LENGTH OF STAY (In yrs.) Yrs.		d. STREET ADDRESS Openshaw Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter A. Cornett, Sr.		4. DATE OF DEATH June 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1909
9. AGE (In years, last birthday, Months, Days, Hours, Min.) 57 yrs.	10. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wiley Cornett		14. MOTHER'S MAIDEN NAME Izora Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO. 215-16-7469	
17. INFORMANT W.A. Cornett, Jr.		Address Markton, Maryland	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO (b) (c) PART 2 OTHERS (IN F CASE CONDITIONS CONTR BUT NOT TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1) Instant			
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above. He had an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Walter A. Cornett, Jr.		DATE SIGNED 6/30/67	
EXAMINER'S NAME (Type or print) Walter A. Cornett, Jr.		ADDRESS (Street, city, town, or county) Markton, Md.	
23a. BURIAL CREMATION REMI VAL (Specify) Burial		23b. DATE THEREOF July 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION (City, town or county) (State) Bel Air, Harford Co., Md.	
24. FUNERAL DIRECTOR Stewartstown, Pa.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REC'D BY REGISTRAR July 5 1967		25c. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATE ON



07729

24. FUNERAL D RECTOR
Walton W. Combs Jr.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

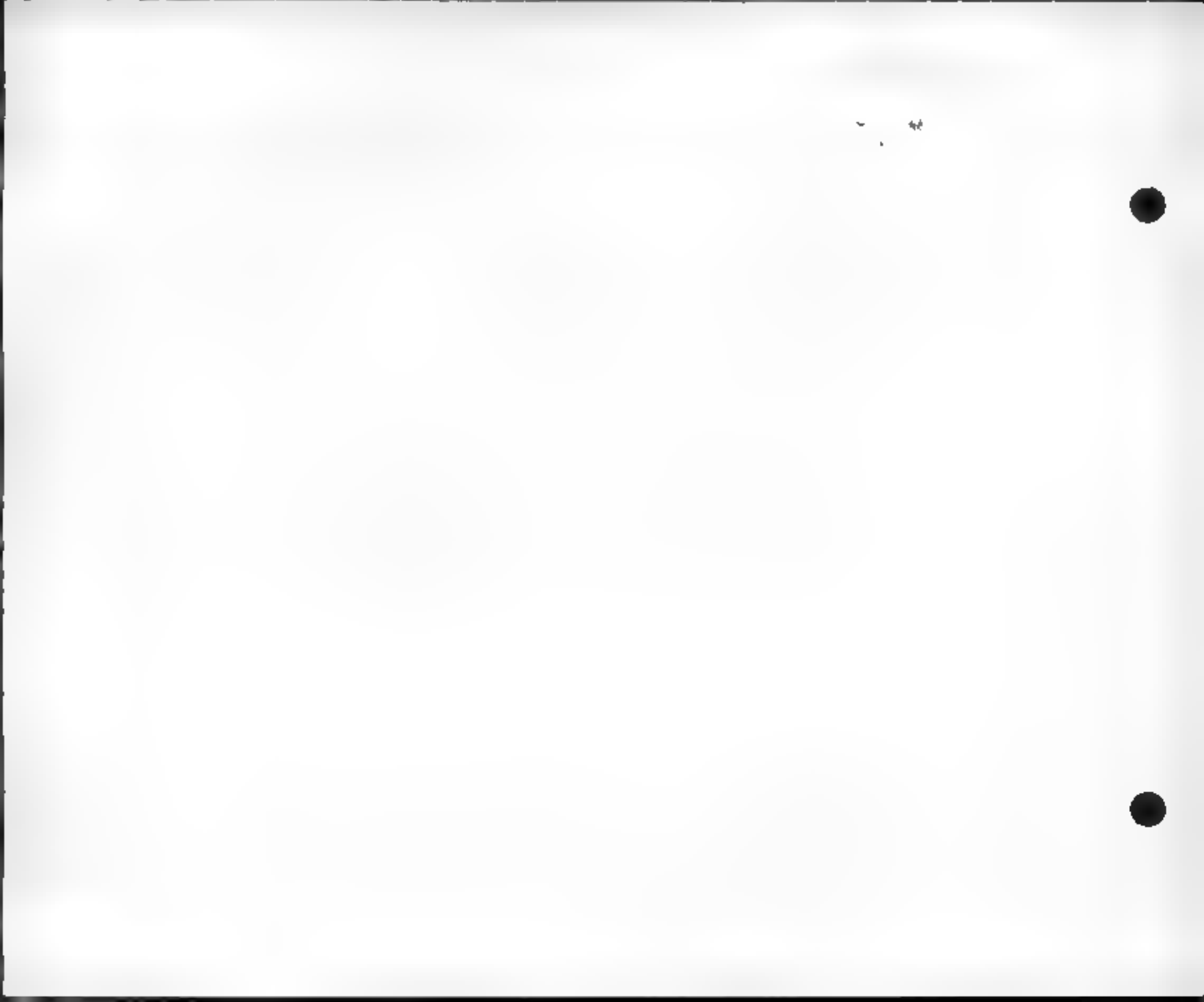
07726

CERTIFICATE OF DEATH

07708

PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN If outside corporate limits write RURAL and give nearest town baltimore		c. STATE Maryland		d. COUNTY	
e. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address. St. Josephs Hospit l		f. STREET ADDRESS 619 S. Montford Avenue		g. RESIDENCE IN A HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>		h. RESIDENCE IN A HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Joseph COLLEY		4. DATE OF DEATH Month Day Year June 25 1967		5. AGE In years last birthday yrs 65		6. IF UNDER YEAR Months Days Hours Min	
7. SEX male		8. COLOR OR RACE white		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH 9-13-1901	
11. OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State or foreign country) Md		14. MOTHER'S MAIDEN NAME	
15. ATEHER'S NAME		16. SOCIAL SECURITY NO		17. INFORMANT Helen County 619 S Montford Ave		18. ADDRESS	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service) No		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY 1962 IMMEDIATE CAUSE (a) Metastatic malignancy DUE TO Conditions if any which gave rise to immediate cause (a). (b) DUE TO Noting the underlying cause (c) For OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISORDER, CONDITION GIVEN IN PART 20		INTERVAL OF 48 HRS ONLY, AND DEATH		21. IF A DEATH CERTIFICATE IS REQUIRED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. IDENTIFY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 20 or Part II of Report)		23a. TIME OF INJURY Month, Day, Year Hour, min, sec June 19 1967		23b. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
24. TIME OF INJURY Month, Day, Year Hour, min, sec June 19 1967		25. PLACE OF INJURY Home, farm, factory, street, office, bldg, etc.		26. TYPE OF INJURY 1. Injury 2. Poison 3. Other		27. DATE OF DEATH June 25 1967	
28. I certify that (this hospital) attended the deceased from June 14 1967 to June 25 1967 that (the) last saw the deceased alive on June 25 1967 and that death occurred at 9:30 PM causes and on the date stated above		29. SIGNATURE Regalado T. Dizon MD		30. ADDRESS 1620 York Road, Baltimore 1204 Md		31. DATE June 25 1967	
32. PHYSICIAN'S NAME Type Regalado T. Dizon I.D.		33. BIRTH DATE 6/24/67		34. NAME OF EMERGENCY OR REMEDY Holy Rosary Cen		35. ADDRESS Baltimore Md	
36. BURIAL CREMATORY REMOVAL SPECIAL B DABROWSKI 2518 E BALTIMORE ST		37. DATE OF BURIAL June 25 1967		38. NAME OF REGISTRAR Charles Judge		39. ADDRESS Baltimore Md	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician. TO FUNERAL DIRECTOR After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to be used as the burial-transit permit. Then please reattach the detached page 3 to the certificate and should be filed with the State Dept of Health prior to burial, cremation or removal and a copy event with 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07727

07709

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN "If inside corporate limits, write RURAL and give nearest town." Lansdowne		2. USUAL RESIDENCE (where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town." Lansdowne	
3. d. NAME OF HOSPITAL OR "If not in hospital, give street address." 2417 Hammonds Ferry Road		d. STREET ADDRESS 2417 Hammonds Ferry Road	
3. NAME OF DECEASED Type or print MILDRED J. CRAIG		4. DATE OF DEATH Month June , Day 7 , Year 1967	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-1907 9. AGE in years last birthday 60 10. UNDER YEARLY IF UNDER 24 HRS Months 0 , Days 0 , Hours 0 , Mins 0	
11. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. BIRTHPLACE (County & State or foreign country) Maryland 13. CITIZENSHIP U.S.A.	
14. FATHER'S NAME Alexander Macajah Francis		15. MOTHER'S NAME Annie L. Grammer	
16. WAS DECEASED EVER IN ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Mr. James F. Craig, 2417 Hammonds Ferry Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: CAUSE BY IMMEDIATE CAUSE a. Multiple breast Ca metastasizing b. Cerebral metastasis c. Ca of breast		INTERVAL BETWEEN ONSET AND DEATH unk. 6 years	
PART II: OTHER SIGNIFICANT CONDITIONS OR RIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISORDER CONDITION GIVEN IN PART I None			
19a. AGE AT DEATH WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 19		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item B) None	
20a. PLACE OF INJURY (Home, road, factory, street, office bldg., etc.) Home		20b. CITY OR TOWN, COUNTY, STATE Lansdowne, Baltimore, Maryland	
21. I certify that (1) this hospital attended the deceased from 19 to 9 and that death occurred at 9 M. from cause and on the date stated above. 22. SIGNATURE Dr. Albert Montague 23. ADDRESS Medical Arts Bldg., Cathedral & Read			
24. BIRTH, REMAIN, OR REMOVAL BURIAL		25. DATE THEREOF 6-10-1967	
26. NAME OF FUNERAL HOME OR CHURCH Meadowridge Cemetery		27. LOCATION (City & town, county, state) Howard County, Maryland	
28. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		29. REC'D BY REGISTRAR J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the necrologist, page 3 shall be detached for use as the burial transcript. Then please remove to burial paper, page 4 and 2 should be filed in the State Dept. of Health, p. 10 to be in compliance with the law.

JUN 12 1967



FOR STATE
HEALTH DEPT

07728

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET BALTIMORE MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07710

1. PLACE OF DEATH
a. BALTIMORE
b. HALETHORPE
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Halethorpe Farms Road
d. NAME OF DECEASED
ANTHONY S.
e. SEX Male f. RACE Negro g. MARRIAGE NEVER MARRIED
h. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE i. KIND OF BUSINESS OR INDUSTRY
NONE
j. FATHER'S NAME
James Daniels
k. SOCIAL SECURITY NO.
NONE

2. USUAL RESIDENCE
a. Maryland
b. Baltimore
c. STREET ADDRESS
1826 E. Chase Street
d. DATE OF DEATH
June 21, 1967
e. BIRTH
7-16-1950
f. BIRTHPLACE (State or foreign country)
Baltimore, Md.
g. CITIZEN OF WHAT COUNTRY?
USA
h. MOTHER
Crothia Young
i. ADDRESS
2434 Mrs Anna Crawford Frederick Ave

3. CAUSE OF DEATH
a. IMMEDIATE CAUSE (a) Drowning
b. DUE TO
c. DUE TO
d. PART DEATH WAS CAUSED BY
e. CONDITIONS (If any which gave rise to death)
f. PAR
g. PRIMARY
h. TIME OF DEATH
8:40
i. DATE
6-21-67
j. WHILE
White
k. FOND
Went swimming, went under and did not surface
l. SIGNATURE
Charles S. Springate
m. NAME
Charles S. Springate, M.D.
n. DATE
June 22, 1967
o. LOCATION
Burial
p. DATE
6-25-67
q. NAME OF CEMETERY OR CREMATORY
St. Calvary Cmt.
r. ADDRESS
2434 E. Chas. St.
s. LOCATION (City or Town) (County) (State)
Baltimore, Md.
t. DATE
JUN 27 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial permit for a person who died in any event within 72 hours after death. It is not to be used for a person who died in any other manner. It is not to be used for a person who died in any other manner. It is not to be used for a person who died in any other manner.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

C7711

77729

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and place them in the envelope provided. The envelope should be filed with the State Department of Health. The certificate should be filed with the State Department of Health.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN CITY OR TOWN 5 DAYS		2 USUAL RESIDENCE (Where deceased lived at in Division before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		e. STREET ADDRESS 1022 E BIDDLE ST		f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) PHILLIP		Middle HENRI		Last CROCKER	
4 SEX M	5 COLOR OR RACE N	6 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF BIRTH 10-13-1916		8 AGE in years, months, and days 50
9a. INDUSTRY, OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		9b. KIND OF BUSINESS OR INDUSTRY		10 BIRTHPLACE (County & State or foreign country) VIRGINIA	
11 FATHER'S NAME ALFRED CROCKER		12 MOTHER'S MAIDEN NAME EUPHANIA JOHNSON			
13a. WAS DECEASED EVER IN U.S. ARMY, OR NAVY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		13b. SOCIAL SECURITY NO. 218-0-8870		14 INFORMANT Records, Mt. Wilson State Hospital	
15a. CAUSE OF DEATH (Enter only one cause per item for a, b, and c) PART I DEATH WAS CAUSED BY 1051 IMMEDIATE CAUSE (a) Pulmonary tuberculosis CONDITIONS, if any, which gave rise to immediate cause (b) Underlying cause (c) 5 years		15b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)		16 WAS A DEATH CERTIFICATE PREPARED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17a. ANATOMICAL FINDINGS (If any) OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 19		17b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a; Part b of item 9c) 19		17c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
18 I certify that this hospital attended the deceased from 6-5-67 to 6-9 19 67 and that the deceased was a 6-9-67 and that death occurred at 2:15 PM on the date stated above		19 SIGNATURE OF PHYSICIAN Wm. Newcomer, M.D., Supt.		20 DATE 6-9-67	
21 BURIAL, CREMATION, REMOVAL, SPECIFIC 6-13-67		22 DATE OF INTERMENT 6-13-67		23 LOCATION OF INTERMENT Oakland, Chaptank, Va.	
24 FUNERAL DIRECTOR Charles A. Rice		25 ADDRESS 601 W. Barre St.		26 REF'D BY BUREAU 6-12-67	



07731

CERTIFICATE OF DEATH

Reg. Dist. No. 07713

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Chapel Hill N. H.		2 USUAL RESIDENCE (Where deceased lived) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 407 Mt Holly St. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Elizabeth S. Crosby First Middle Last 4 DATE OF DEATH June 4, 1967 Month Year Day		5 SEX F 6 COLOR OR RACE Cauc. 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH Oct. 1, 1873 Month Year Day	
9 AGE in years last birthday 93 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? USA		3. FATHER'S NAME George W. Crosby 4. MOTHER'S MAIDEN NAME Sarah Irine	
5. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) 16 SOCIAL SECURITY NO. 213-34-7174 INFORMANT J. Joseph Foster Address 407 Mt Holly St.		8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arteriosclerosis Condition (b) any which gave rise to immediate cause (c). Stating the underlying cause last. PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 8 Carcinoma of the liver 19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> IF EITHER NOTIFY MEDICAL EXAMINER 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 8 or Part of item 8) 20c. TIME OF INJURY Month. Day Year 1967 10 6 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY Home, farm, factory, street, office, etc. Home 20f. CITY OR TOWN (County) (State)		21 I certify that attended the deceased from 1967 10 6 to 1967 10 6 that I last saw the deceased alive on 1967 10 6 and that death occurred at 4:00 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Liberty Rd. DATE SIGNED 7/26/67	
ACTUAL SIGNATURE William E. Martin PHYSICIAN'S NAME (Type) William Martin, M. D.		22a. BURIAL CREMATION, REMOVAL, SPECIFY BURIAL 22b. DATE THEREOF 6/6/67 22c. NAME OF CEMETERY OR CREMATORY London Park Cem. 22d. LOCATION (City, town or county) (State) Baltimore, Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR J N DATE 1967 24b. REGISTRAR'S SIGNATURE Michael J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or conveyance within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

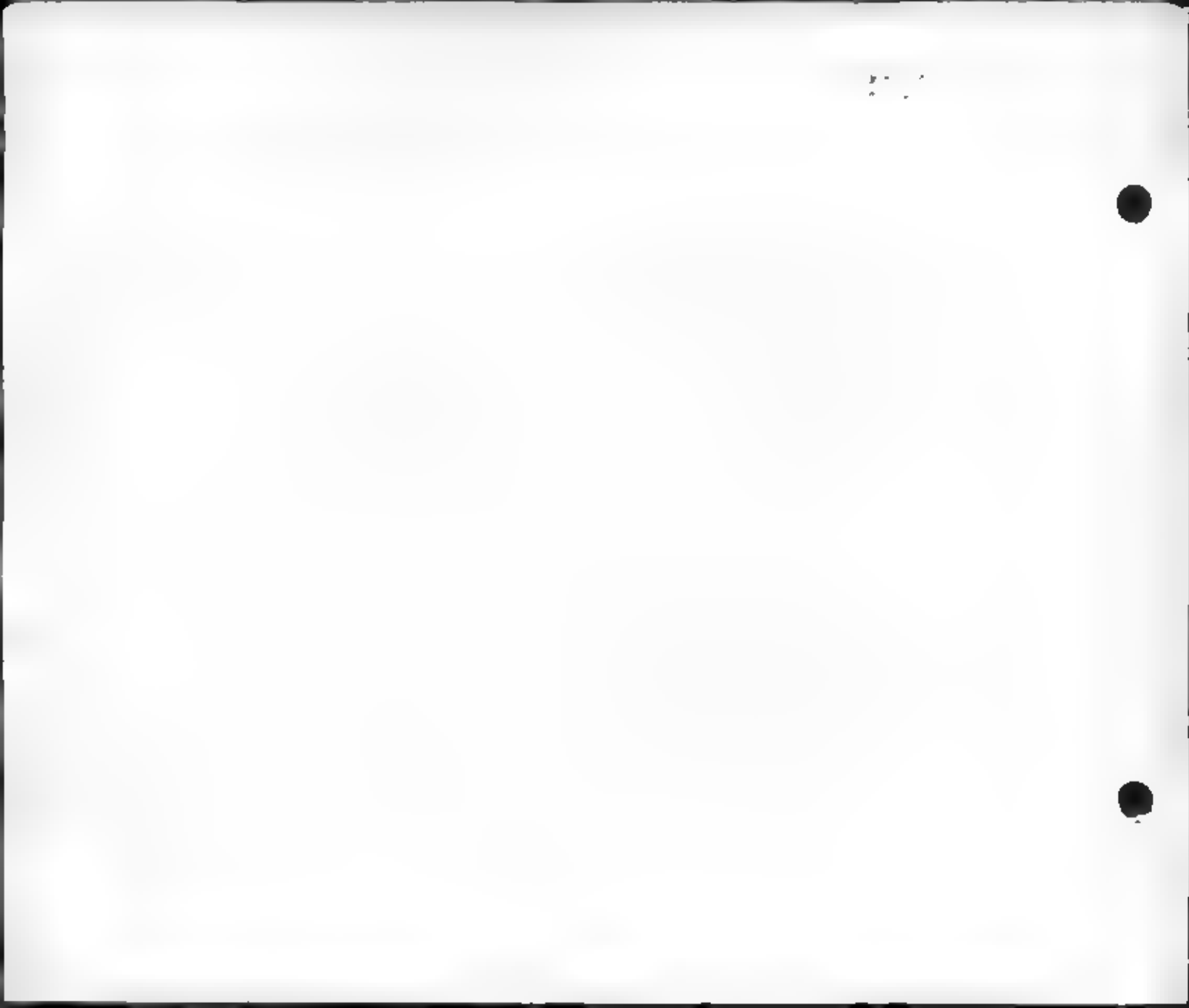
97730

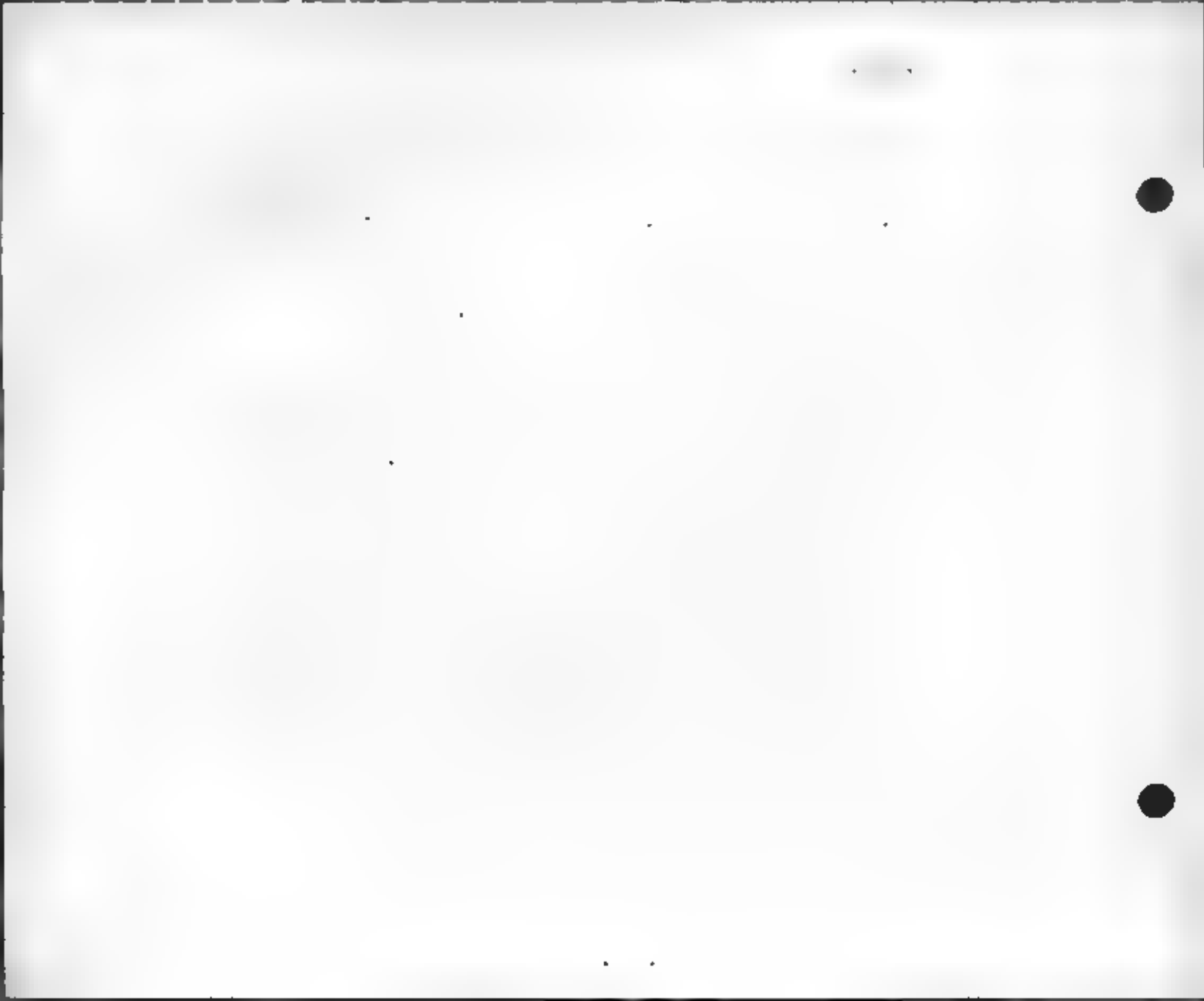
CERTIFICATE OF DEATH

07712

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Timonium</i> c. LENGTH OF STAY IN 15 <i>Timonium</i>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>alto</i> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Timonium</i> d. STREET ADDRESS <i>2046 York Road</i>	
3 NAME OF DECEASED (Type in print) First <i>Samuel</i> Middle <i>T.</i> Last <i>Crowther</i>		4 DATE OF DEATH Month <i>June</i> Day <i>5</i> Year <i>57</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Nov. 7, 1899</i>
9 AGE in years (less birthday) <i>67</i>		10 IF UNDER 1 YEAR Months <i>6</i> Days <i>1</i> Hours <i>15</i> Min <i>00</i>	
11a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Landlord</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Real estate</i>	
12 BIRTHPLACE (County & State or foreign country) <i>ar land</i>		13 IF CITY OF WHAT COUNTRY? <i>USA</i>	
14 FATHER'S NAME <i>Samuel S. Crowther</i>		15 MOTHER'S MAIDEN NAME <i>Mary Collins</i>	
16 WAS DECEASED MARRIED OR ARMED FOR? (Yes, no, or unknown) (If yes give war or dates of service) <i>no none</i>		17 SOCIAL SECURITY NO <i>215-05 6774</i>	
18 INFORMANT <i>Family records</i>		Address	
19 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <i>CORONARY ART. DISEASE</i> Conditions, if any, which gave rise to immediate cause (b) DUE TO <i>EUPHYSEMA -</i> DUE TO <i>ASTHMA -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 YR</i> <i>20 YR</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE. (CONDITN GIVEN IN PART I) <i>COMPLETE HEART BLOCK</i>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. 41. DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF YES, NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OR ILLNESS ENTERED NOTICE OF INJURY IN PART I OR PART II OF SLIP 82	
21a. TIME OF INJURY Month Day Year Hour <i>am</i> Min <i>00</i> PM <i>00</i>		21b. INJURY OR ILLNESS While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. PLACE OF INJURY Home or locality street or place of birth		21d. City or town County State	
2 certify that with a hospital attended the deceased on <i>5-1-67</i> and I got death of <i>445A</i> causes and on the date stated above		22a. SIGNATURE OF PHYSICIAN <i>Ronald O. Wood MD</i>	
22b. DATE SIGNED <i>6-2-67</i>		22c. PHYSICIAN'S NAME <i>RONALD O. WOOD</i>	
23a. BUREAU OF NATIONAL RECORDS <i>Bureau</i>		23b. DATE THROU <i>6/7/57</i>	
23c. NAME OF TEMPORARY OR PERMANENT <i>Maryland Memorial Park</i>		23d. OLD LOCATION <i>arkville</i>	
24. FUNERAL DIRECTOR <i>John Jones Sons</i>		25a. RECORD BY REGISTER <i>Towson, Md. 21204</i>	
25b. REGISTER'S SIGNATURE <i>John Jones Sons</i>		25c. DATE <i>JUN 12 1967</i>	

VA 15 4
25M 67





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07733

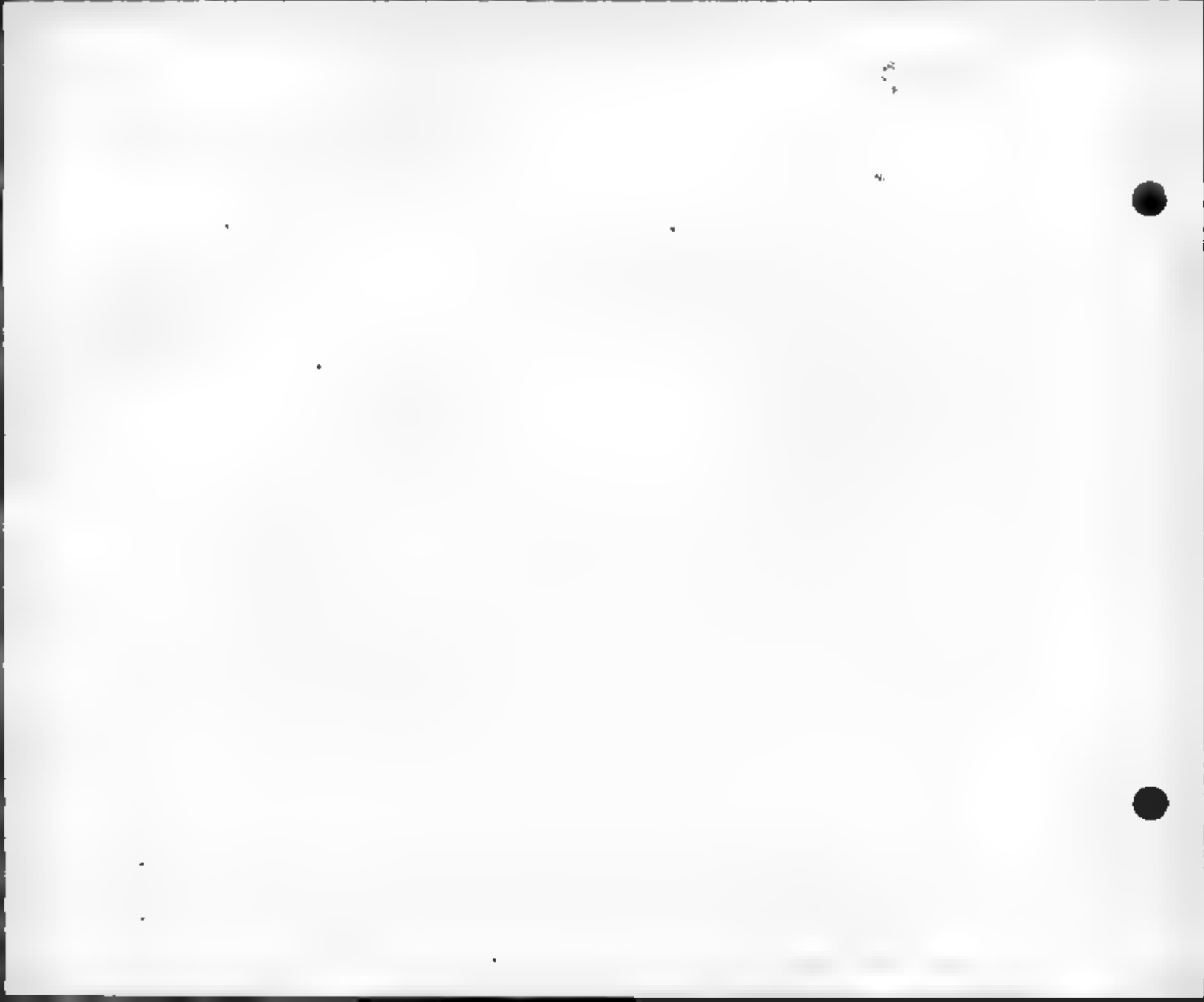
CERTIFICATE OF DEATH

07715

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if in institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN EB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1700 Middleborough Rd.		e. STREET ADDRESS 1700 Middleborough Rd.	
3. NAME OF DECEASED First Middle Last ESTELLA J. DeBAUFRE		4. DATE OF DEATH Month Day Year June 21, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1890
9. AGE in years last birthday 76		10. IF UNDER 1 YEAR Months Days Hours Mins	
11. OCCUPATION (Give kind of work done during life, or state if retired) Housewife		12. KIND OF BUSINESS OR HOME Home	
13. FATHER'S NAME Daniel Geotz		14. MOTHER'S MAIDEN NAME Elizabeth Clinton	
15. WA OF ASC VER IN ARME (OR ESP) (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 216 05 8450	
17. INFORMANT Henry DeBaufre		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE to conditions if any which gave rise to immediate cause of, stating the underlying cause last. (a) Coronary occlusion (b) Art. sclerotic card. & averse disease (c)			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (c))			9. WA 2. OPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OR IRRITATION White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1956 to June 1967 that (I) (we) last saw the deceased alive on June 21, 1967 and that death occurred at 10 P M. from causes and on the date stated above			
22a. SIGNATURE Louis Semenoff		22b. DAY SIGNED 6/22/67	
22c. PHYSICIAN NAME (Y or N) Louis Semenoff, M. D.		22d. ADDRESS 2108 Orens Rd. Baltimore, Md. 2120	
23a. BURIAL CREMATION Burial (Specify)	23b. DATE THEREOF 6/26/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR Brudzinski Funeral Home		25. REG'D BY REGISTRAR JUN 23 1967	
26. ADDRESS Home 1407 Eastern Ave.		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

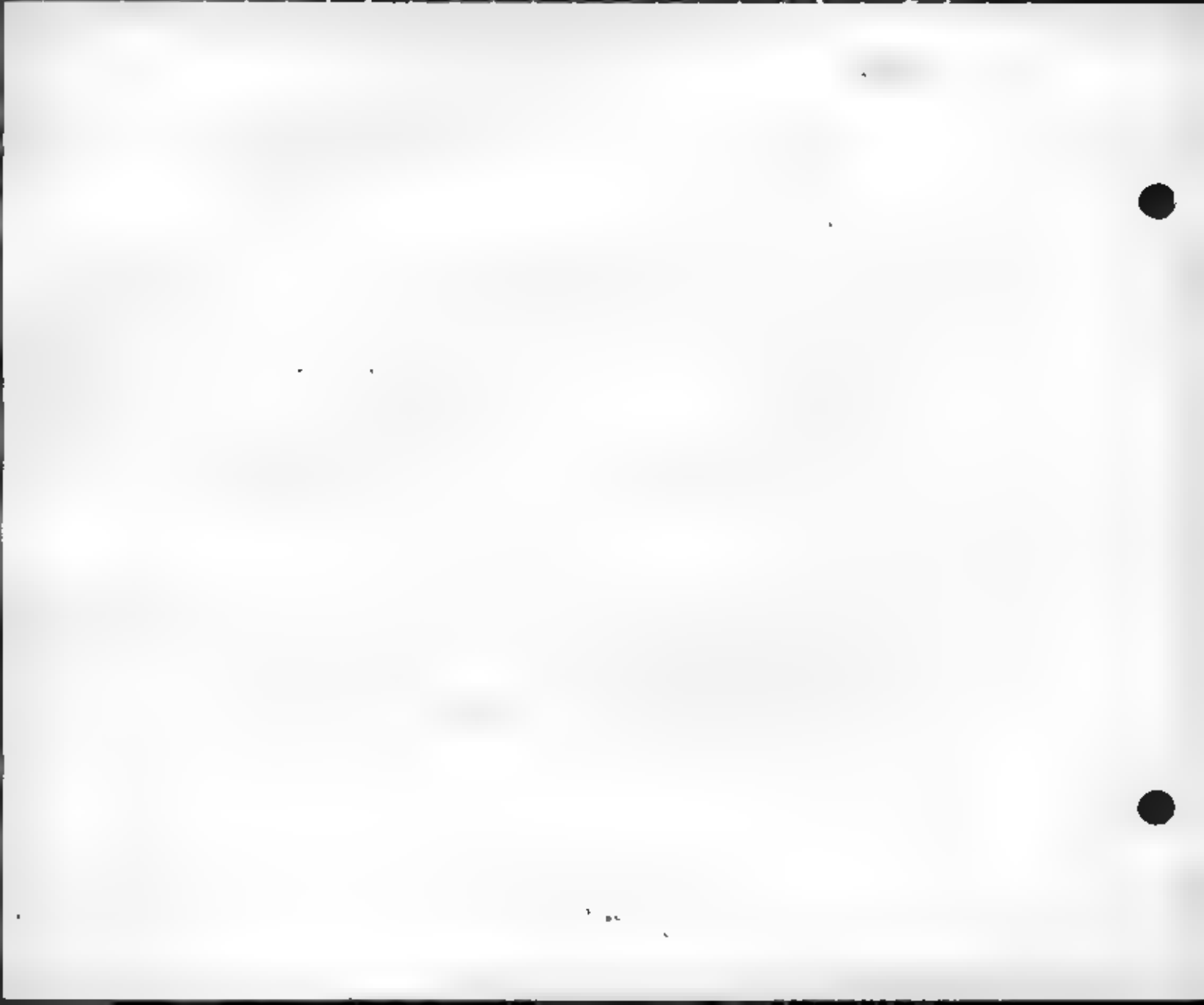
077734

CERTIFICATE OF DEATH

07716

1 PLACE OF DEATH a COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE Where deceased lived if institution. Residence before admission a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN <u>Baltimore</u> (If outside corporate limits write RURAL and give nearest town)		c LENGTH OF STAY IN "b" <u>13</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Balto. Co. Gen. Hospital</u>		d STREET ADDRESS <u>Henry Deitz</u>	
3 NAME OF DECEASED Type "a" print <u>Clarence E. Deitz</u>		e DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1967</u>	
SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> WORKED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-23-43</u>
9 AGE in years on birthday <u>74</u>		10 IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> Hours <u>1</u> Min. <u>0</u>	
10a K. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)		10b KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11 FATHER'S NAME <u>Henry Deitz</u>		14 MOTHER'S MAIDEN NAME <u>Annie Penn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war in dates of service)		16 SOCIAL SECURITY NO <u>220-34-7285</u>	
17 INFORMANT <u>Mr. Ralph Deitz</u>		25 Sheraton Road Randallstown, Md 21133	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>Myocardial Infarction</u> <u>Coronary artery disease</u> CONDITIONS (any which gave rise to immediate cause (a), stating the underlying cause last) (b) <u>Arteriosclerosis</u> (c) <u>Coronary artery disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Arteriosclerosis</u>			
20a ACIDENT WAS INJURYING () OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month Day Year Hour <u>19</u> min. <u>0</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home farm, factory, street, office bldg., etc.		20f (City or town) (County) (State)	
2 I certify that (1) (th) (s) hospital () attended the deceased from <u>June 6</u> 19 <u>67</u> to <u>June 6</u> 19 <u>67</u> that (1) (th) (s) we last saw the deceased alive on <u>June 6</u> 19 <u>67</u> and that death occurred at <u>10:00 PM</u> from causes and on the date stated above.			
22a SIGNATURE <u>John Darrell</u> J. DARRELL		22b DATE SIGNED <u>6-6-67</u>	
23a BURIAL OR CREMATION <u>Burial</u>		23b DATE THEREOF <u>6/9/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d LOCATION City or Town <u>Randallstown</u>	
23e COUNTY <u>Balto Co.</u>		23f STATE <u>Md.</u>	
24 FUNERAL DIRECTOR <u>87-28 Leitch Rd</u> <u>John R. Ryan</u>		25a REC'D BY REGISTRAR <u>John R. Ryan</u>	
25b REGISTRAR'S SIGNATURE <u>John R. Ryan</u>		25c DATE <u>JUN 8 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript, permit. The permit, page 3, should be filed with the State Department of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if subsequent with a 72-hour safe death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07735

CERTIFICATE OF DEATH

07717

PLACE OF DEATH a. COUNTY Baltimore MARYLAND		b. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville		d. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Essex (21)	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home		f. STREET ADDRESS 328 George Ave.	
3. NAME OF DECEASED (Type or print) ROBERT L. DENNIS		4. DATE OF DEATH Month June Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1881
9. AGE in years 86		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
11. OCCUPATION (Give kind of work done during most of waking life, even if retired) Farmer		12. KIND OF BUSINESS OR INDUSTRY Farming	
13. BIRTHPLACE (County & State or foreign country) Mississippi		14. CITIZENSHIP (WHAT COUNTRY?) USA	
15. FATHER'S NAME Greene Dennis		16. MOTHER'S MAIDEN NAME Smith	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. william Dennis Same	
19. INFORMANT william Dennis		Address Same	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, cardiac - chronic DUE TO hypertension CONDITIONS (any which gave rise to immediate cause or, stating the underlying cause for (b) hypertension DUE TO hypertension DUE TO hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ALICENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
24. TIME OF INJURY Month Day Year Hour 19 min PM		25. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town) (County) (State)	
28. I certify that (If s-hospital) attended the deceased from 1966 to 1967 that (I) have lost saw the deceased alive on 6/14 19 67 and that death occurred at 4:15 PM from causes and on the date stated above			
29a. SIGNATURE John Shaw, M.D.		29b. DATE SIGNED 6/13/67	
30. PHYSICIAN'S NAME (Type) John Shaw, M.D.		31. ADDRESS 5800 Edmondson Ave.	
32a. BURIAL, CREMATION, OR DISPOSITION Removal		32b. DATE THEREOF June 14, 1967	
33. NAME OF CEMETERY OR CREMATORY Thompson Funeral Home		34. LOCATION (City or town) (County) (State) Laurel, Mississippi	
35. FUNERAL DIRECTOR Brzezinski Funeral Home		36. ADDRESS 1407 Eastern Ave.	
37a. REC'D BY REGIS. RAR DATE 6/15 1967		37b. REGIS. RAR'S SIGNATURE James L. Shaw	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A 514
20 14 66

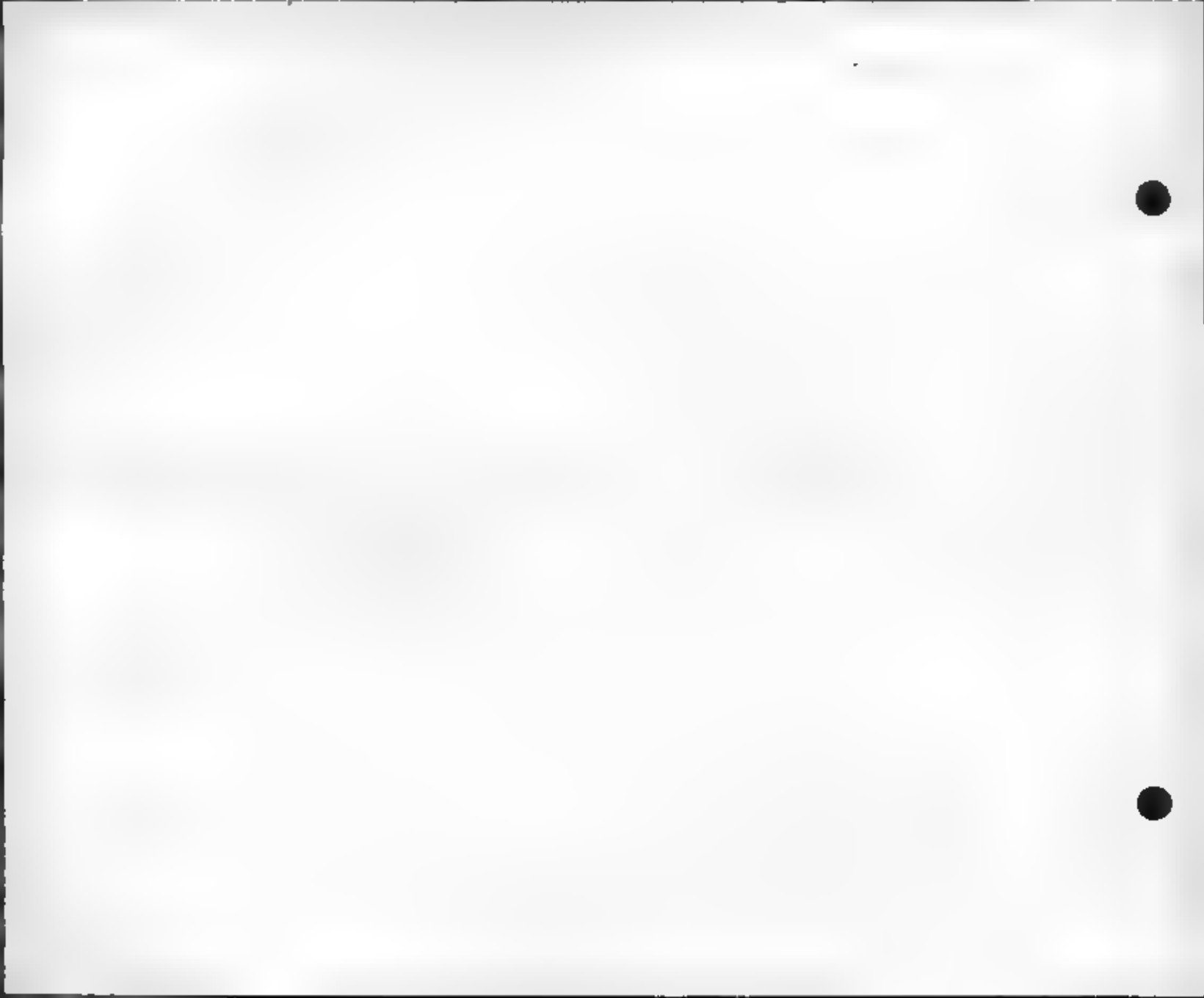
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07736

CERTIFICATE OF DEATH

07718

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town) Mount Wilson		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 3, 53 LENDY LANE	
3. NAME OF DECEASED (Print) EDWARD M. DICK		4. DATE OF DEATH Month 1 Day 24 Year 1967	
5. SEX M	6. COLOR OF RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/06
9. AGE in years 105 birthday 50 yrs.		10. IF UNDER 24 HRS. Months Days Hour Min	
11. USUAL OCCUPATION (Give kind of work done during or at working life even if retired) RETIRED		12. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13. FATHER'S NAME APOLLIS DICK		14. MOTHER'S MAIDEN NAME SARAH SENGLE	
15. WAS DECEASED EVER IN ARMED FORCES (Yes, no, draft point) (All yes give war or dates of service) None		16. SOCIAL SECURITY NO. 577-50-7577	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Coronary Thrombosis DUE TO (b) Myocardial Infarction DUE TO (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. None		18. TIME OF DEATH (Between 12:00 and 12:59) 12:00	
19. A. IDENTIFY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) 20a. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. CITY or town County State	
21. I certify that (I) (this hospital) attended the deceased from 6 June 1967 to 24 June 1967 that (we) last saw the deceased alive on 24 June 1967 and that death occurred at 4 M. from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 24 June 1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL INFORMATION (Specify)	23b. DATE OF BURIAL June 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery Burtonsville, Maryland	
24. FUNERAL DIRECTOR Warner E. Fumphae, Inc.		25. REG. BY REGISTRAR Phonias Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove the pages and 2. This page should be filed with the State Dept. of Health prior to burial, cremation or removal, and a copy given within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07737

CERTIFICATE OF DEATH

07719

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If not in corporate limits, write RURAL and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) White Marsh, Maryland	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS Bird River & Vincent Rds.	
3 NAME OF DECEASED (Type in print) Joseph P. Diepold, Jr.		4 DATE OF DEATH Month 6 - Day 28 - Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-3-15
9 AGE (In years, months, and days) 51		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> IF UNDER 1 YEAR, Month <input type="checkbox"/> Day <input type="checkbox"/> Hour <input type="checkbox"/> Minute <input type="checkbox"/>	
11a. OCCUPATION (Give kind of work done during most of working life, ever if retired) Self employed		11b. KIND OF BUSINESS OR INDUSTRY Tavern	
12 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		13 TITLE OF WHAT COUNTRY U.S.A.	
14 FATHER, NAME Joseph P. Diepold Sr.		15 MOTHER'S MAIDEN NAME Margaret Ensor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; if unknown, fill in yes, give war or dates of service) NO		16b. SOCIAL SECURITY NO. 214-34-3958	
17 INFORMANT Mr. Ronald L. Dowling		Address 125 Linhigh Avenue 21236	
18 CAUSE OF DEATH (Write on one cause per line for 1a, 1b, and 1c) PART I: IMMEDIATE CAUSE Carcinomatosis with widespread metastasis with left kidney involment post left nephrectomy post left pneumonectomy		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (GIVEN IN PART I)		19a. WAS A POSTMORTEM PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 20b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) 20c. CITY OR TOWN, COUNTY, STATE		20d. CITY OR TOWN, COUNTY, STATE	
21. I certify that (1) this hospital attended the deceased from June 27, 1967 to June 28, 1967 and that death occurred on June 28, 1967 at 3:35 AM from cause, and on the date stated above		22. SIGNATURE OF PHYSICIAN Efraim Reyes, M.D.	
23a. PHYSICIAN NAME (Type in print) Efraim Reyes, M.D.		23b. ADDRESS 7620 York Road Baltimore 21204, Md.	
24. BURIAL REMOVAL (Type in print) 1-1-1967		25. NAME OF FUNERAL HOME OR CREMATORY Gardens of Faith Cemetery Baltimore Co. Md.	
26. FUNERAL DIRECTOR		27a. REG'D BY REGISTRAR June 28, 1967	
27b. REGISTRAR'S SIGNATURE Charles Judge		28. DATE JUL 3 1967	

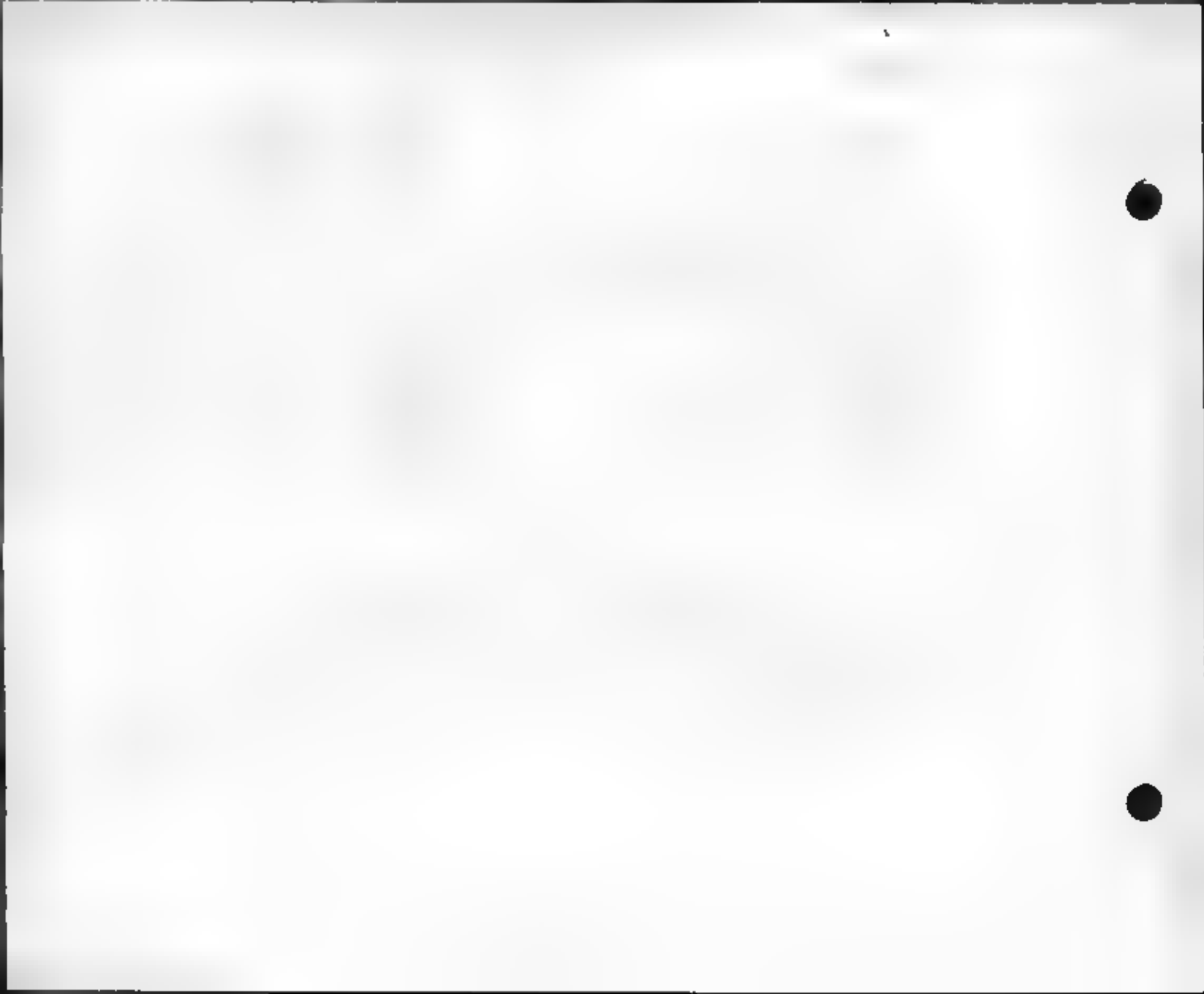


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07738 CERTIFICATE OF DEATH 07720

1. PLACE OF DEATH a. COUNTY <u>Balt. more</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Maryland</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Convalescent</u>		2. USUAL RESIDENCE (Where deceased lived, if that different: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7836 Bagley Ave</u> e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Dunn</u> First Middle Last 4. DATE OF DEATH <u>6/14/67</u> Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/29/1885</u> 9. AGE (in years last birthday) <u>81</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Bien</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOC. SEC. NO. <u>17. INFORMANT</u> <u>Mrs Catherine Pasco-7836 Bagley</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Denges</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> 433. DUE TO <u>with chronic f. bullefin</u> (b) <u>chronic Brain Syndrome</u> DUE TO <u>Associated with Generaliz.</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE SECONDARY TO VEN IN PART I (a) <u>Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day Year <u>3/10/65</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, etc.) <u>at work</u> 20f. (City or town) (County) (State)		21. I certify that (I) (th) hospital attended the deceased from <u>3/10/65</u> to <u>6/14/67</u> that (I) (we) saw the deceased alive on <u>6/14/67</u> and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above 22a. SIGNATURE <u>W E McGraw M.D.</u> 22b. PHYSICIAN'S NAME (Type) <u>W E McGraw M.D.</u> 22c. ADDRESS <u>1303 Frederick Rd Catonsville Md</u> 22d. DATE SIGNED <u>6/15/67</u>	
23a. BURIAL CREMATION, REMOVAL Specify <u>Burial</u> 23b. DATE THEREOF <u>6/17/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem Bal</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore</u>		24. FUNERAL DIRECTOR <u>John C Miller Inc - 6415 Belair Rd</u> 25a. REC'D BY REGISTRAR <u>19 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Young</u>	

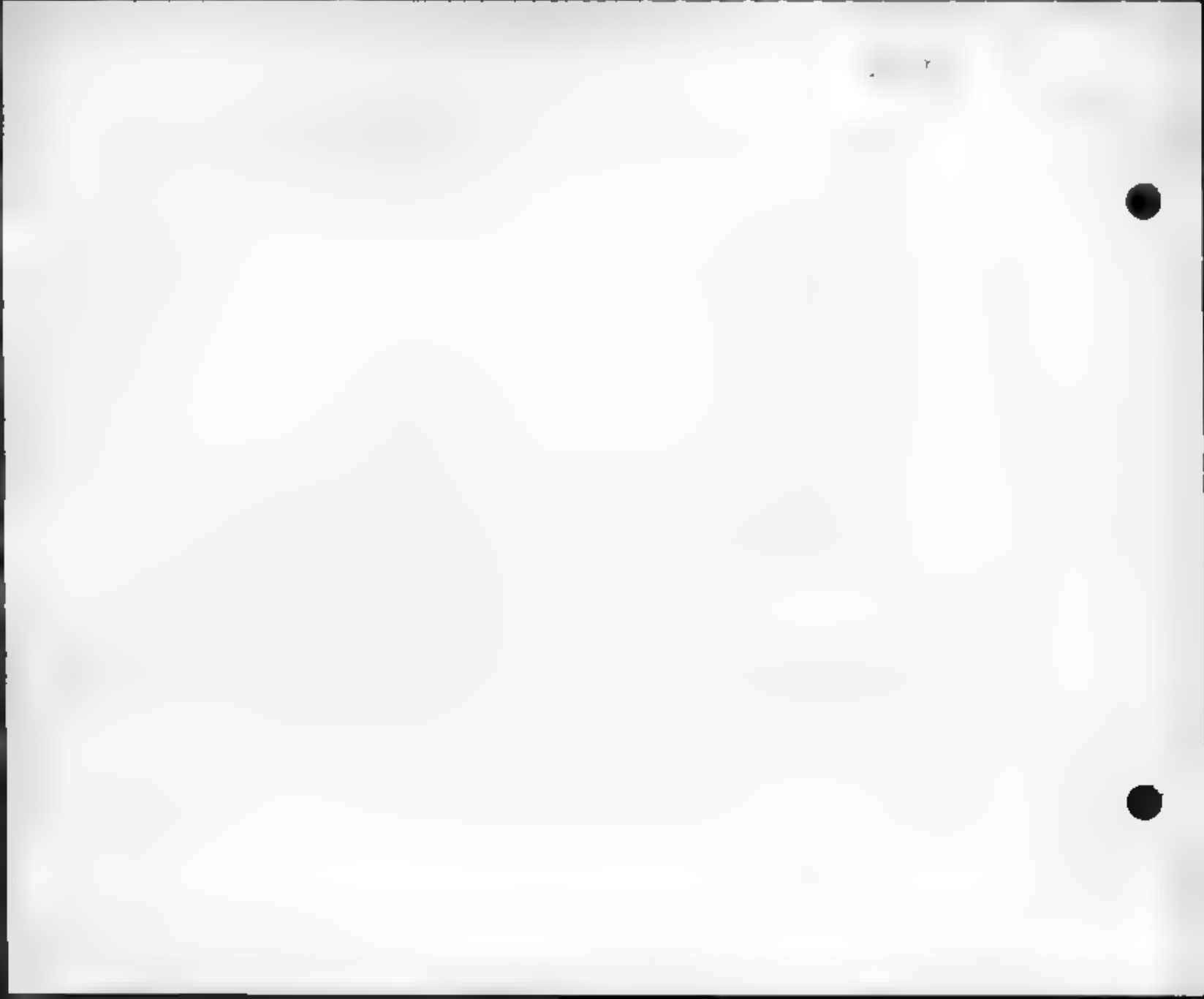


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy sent within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
07733						CERTIFICATE OF DEATH						07721	
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7107 MARTELL AVE</u>						d. STREET ADDRESS <u>7107 MARTELL AVE</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) First Middle Last <u>FREDERICK EDER</u>						4. DATE OF DEATH Month Day Year <u>JUNE 12 1967</u>							
5. SEX <u>MALE</u>						6. COLOR OR RACE <u>WHITE</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Month Day Year <u>SEPT 14 1896</u>						9. AGE (In years last birthday) <u>70</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RIVERIER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>SHIPYARD</u>						11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>WILLIAM EDER</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH LAPPIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>						16. SOCIAL SECURITY NO. <u>21307-028</u>						17. INFORMANT <u>MRS. AMELIA EDER MARTELL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF NECK</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____						PART II OTHERS SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, school bldg., etc.)	
20f. (City or town) (County) (State)													
21. I certify that (i) (this hospital) attended the deceased from <u>1959</u> to <u>6/12/67</u> 19. that (i) (we) last saw the deceased alive on <u>6/9/67</u> 19. and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>W E Baerman MD</u>						22b. ADDRESS <u>340 DUNDALK AVE</u>						22c. DATE SIGNED <u>6/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W E. BAERMAN MD</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>JUNE 15 1967</u>						23c. NAME OF CEMETERY OR CREMATORY <u>CARL LAWL CEMETERY COLLEGE</u>	
23d. LOCATION (City, town or county) (State) <u>DUNDALK MD</u>						24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>						25. REC'D BY REG STRAR <u>UN 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													



TO DEPUTY MEDICAL EXAMINER. The estate should be executed within 24 hours after death if any delay necessary, please execute the certificate writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR. The body should be laid out and removed from the State Department of Health prior to burial. It must be removed and in any event within 72 hours after death.

TO FUNERAL DIRECTOR
The following is a list of persons who are permitted to be present at the funeral of the deceased, and in any event within 72 hours after death. The State Department of Health is not responsible for the accuracy of the information.

WM A SIME (1)
601 1 67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07722

PLACET OF DEATH a. COUNTY BALTO		USUAL RESIDENCE (While deceased lived in it) b. h. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBOURGH MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBOURGH MD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 206 IRLED AVE. RD		d. STREET ADDRESS 206 IRLED AVE. RD	
1. NAME OF DECEASED First Middle Last EDWARD S. ELDER JR.		4. DATE OF DEATH Month Day Year JUNE 12 1967	
5. SEX M 6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH AUG 13 1962		9. AGE at birth Day Month Year 4	
a. If not in hospital, at what place of work, date during last 14 working days, even if injured MD		b. BIRTHPLACE (State or foreign country) USA	
3. FATHER'S NAME EDWARD S. ELDER SR		11. MOTHER'S MAIDEN NAME ALICE K. H. J.	
10. CAUSE OF DEATH (If fatal, give cause of death; if not fatal, give cause of death) 9090 IMMEDIATE CAUSE (a) DUE TO (b) (c)		12. INFORMATION EDWARD ELDER SR, ABC	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		13. WAS AUTOPSY PERFORMED? 1	
14. I certify that the cause of death is the result of the above conditions and that the death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Undetermined <input type="checkbox"/>		15. SIGNATURE OF EXAMINER M. B. J. S. MD - 68	
16. SIGNATURE OF FUNERAL DIRECTOR J. G. CONNELLY SONS		17. DATE OF DEATH 6/15/67	
18. ADDRESS OF FUNERAL HOME 300 MACE		19. DATE OF DEATH JUN 16 1967	



TO DEPUTY MEDICAL EXAMINER The case above should be extended when the date of death is delayed beyond the period of time the work properly in place in item 8 Give Pages 1, 2 and 3 the new date. Page 4 should be forwarded to the Chief Medical Examiner. On the morning of the PMJ Page 5 should be forwarded to the District Attorney, permit five pages and 2 with the 4 to be returned to the District Attorney and in any event within 72 hours after death.

TO FUNERAL DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 30 W. PRESTON STREET BALTIMORE MARYLAND 21201

97723

PLACE OF DEATH BALTIMORE		USUAL RESIDENCE Maryland	
NAME OF DECEASED ONEIDA MARY ELLEN ELSEROAD		NAME OF DECEASED Mary Ellen Elseroad	
SEX Female		SEX Female	
RACE White		RACE White	
OCCUPATION Housekeeper		OCCUPATION Housekeeper	
NAME OF NEXT OF KIN Samuel Elseroad		NAME OF NEXT OF KIN Ida Raver	
ADDRESS Rt. W3 Mt. Gilead Road		ADDRESS Rt. #3 Mt. Gilead Road	
DATE OF DEATH Dec. 5, 1909		DATE OF DEATH June 17, 1967	
PLACE OF BIRTH Carroll Co.		PLACE OF BIRTH Carroll Co.	
SOCIAL SECURITY NUMBER 212-40-6882		SOCIAL SECURITY NUMBER 212-40-6882	
CAUSE OF DEATH Shotgun wound of right lower leg		CAUSE OF DEATH Shotgun wound of right lower leg	
MANNER OF DEATH Shot by unknown assailant		MANNER OF DEATH Shot by unknown assailant	
TIME OF DEATH 9:50		TIME OF DEATH 6-17 67	
PLACE OF DEATH Reisterstown Balt. Md.		PLACE OF DEATH Reisterstown Balt. Md.	
SIGNATURE OF EXAMINER Charles S. Springate, M.D.		SIGNATURE OF EXAMINER Charles S. Springate, M.D.	
DATE OF DEATH June 21, 1967		DATE OF DEATH June 21, 1967	
PLACE OF DEATH Reisterstown, Balto. Co. Md.		PLACE OF DEATH Reisterstown, Balto. Co. Md.	
FUNERAL HOME Tipton - Eline Funeral Home Hampstead, Md.		FUNERAL HOME Tipton - Eline Funeral Home Hampstead, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07742

07724

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armstrong Nursing Home</u>		e. STREET ADDRESS <u>812 Kuykendahl 3335 Chestnut Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mame</u> Middle <u>Elise</u> Last <u>Enser</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Heflin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bayne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 09 5816 B</u>	
17. INFORMANT <u>Vernon Enser</u>		Address <u>1924 Englewood Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a. IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> b. DUE TO <u>Cardiac infarction</u> c. DUE TO <u>Arteriosclerosis</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6:45</u> p.m. <u>4:45</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>9-6-67</u> to <u>6-19-67</u> , that (ii) (we) last saw the deceased alive on <u>6-19-67</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. DuVall</u>		22b. DATE SIGNED <u>6/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. DuVall</u>		22d. ADDRESS <u>Mt Vernon Medical Bldg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 23 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Butcher Funeral Home</u>		25a. REC'D BY REG. STRAN <u>2631 Falls Rd</u>	
25b. REC. STRAN'S SIGNATURE <u>John J. Judge</u>		DATE <u>6-20-67</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If you do not have the necessary information, please indicate the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. The funeral director should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. This may be returned for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

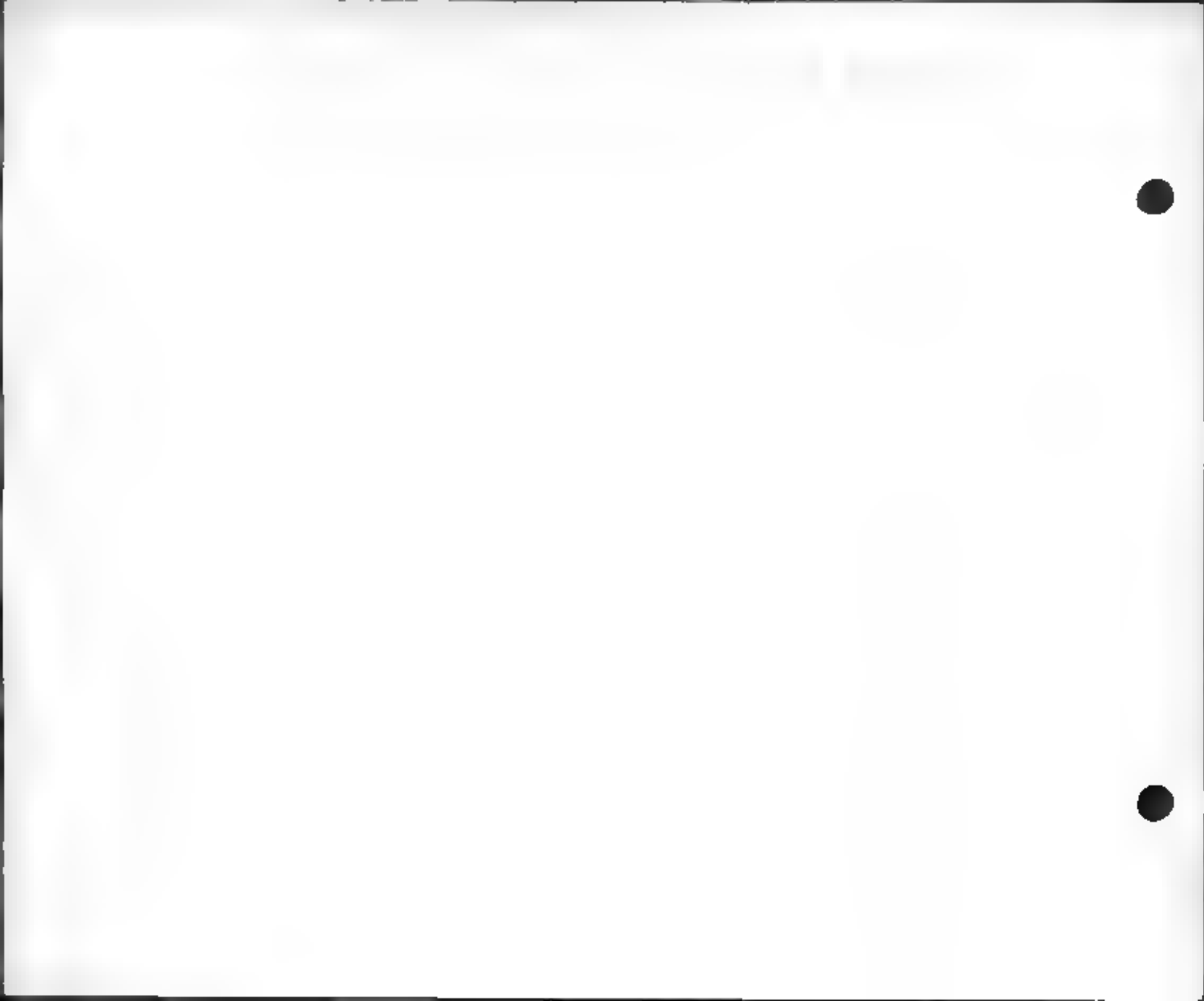
VR 4-5 ME
6-2-66

07743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07725

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE Where deceased lived a. STATE <u>Maryland</u>	
b. CITY OR TOWN <u>Baltimore</u>		b. COUNTY <u>Baltimore</u>	
c. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address <u>St. Joseph Hospital</u>		d. TRAIL ADDRESS <u>Home</u>	
e. NAME OF DECEASED <u>Pennis "Esposito"</u>		f. DATE OF DEATH <u>June 16 1967</u>	
g. SEX <u>M</u> RACE <u>White</u>		h. AGE <u>23</u>	
i. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		j. DATE OF BIRTH <u>1943</u>	
k. PLACE OF BIRTH <u>Baltimore, Md.</u>		l. BIRTHPLACE <u>Baltimore, Md.</u>	
m. FATHER'S NAME <u>Anthony M. Esposito</u>		n. MOTHER'S MAIDEN NAME <u>Carmela D. DiF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Andre</u>	
17. INFORMANT <u>Andre</u>			
18. CAUSE OF DEATH a. PAR. 1. OTHER SIGNIFICANT LONG TERM CONTRIB. TO DEATH <u>1098</u> b. CAUSE OF DEATH <u>Striking</u> c. CONDITIONS AT TIME WHICH GAVE RISE TO DEATH <u>Striking</u> d. MEDICAL OPINION <u>Striking</u>			
19. EXTERNAL CAUSE WAS PRIMARY OR SECONDARY? <u>Primary</u>			
20. INTERNAL CAUSE WAS PRIMARY OR SECONDARY? <u>Primary</u>			
21. CERTIFY THAT I took charge of the deceased and held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE OF EXAMINER'S NAME Type <u>Charles F. O'Donnell, M.D.</u>		23. DATE SIGNED <u>6/16/67</u>	
24. BURIAL REMAINING REMOVED? <u>Specified</u>		25. DATE HEREIN <u>6/16/67</u>	
26. NAME OF FUNERAL HOME <u>Decker</u>		27. ADDRESS <u>Baltimore, Md.</u>	
28. REC'D BY REGISTRAR <u>UN 19 1967</u>		29. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The following requirements shall be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial transit permit. Then please remove a copy of pages 1 and 2 and return them to the State Department of Health. Page 4 should be filed with the State Department of Health.

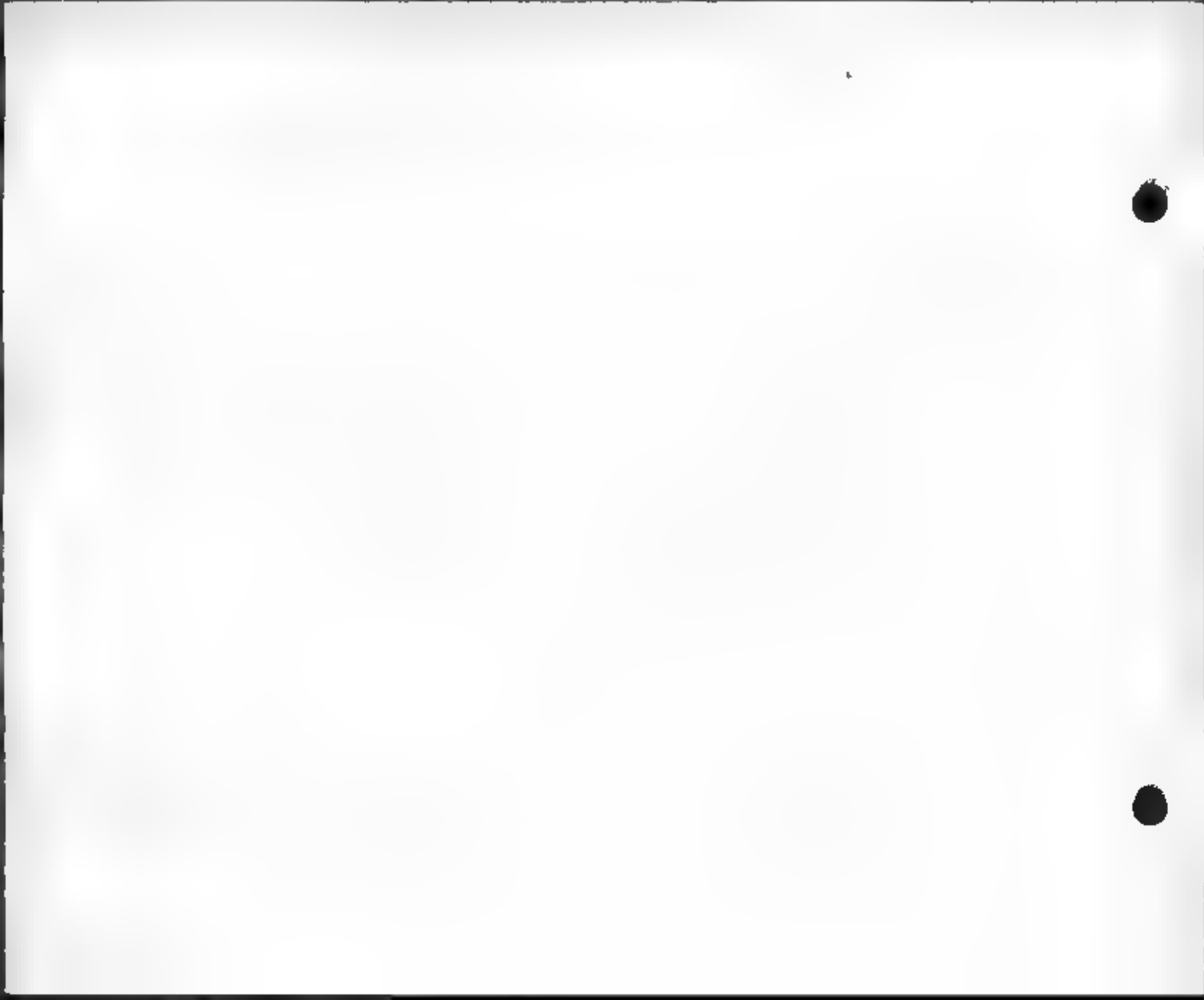
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07744

CERTIFICATE OF DEATH

07726

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b. St. Joseph Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Glen Arm, 21057 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 663-9	
3 NAME OF DECEASED Type of print Rosa First Middle Last EVANS		4 DATE OF DEATH Month Day Year June 18, 1967	
5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8 DATE OF BIRTH 11-12-1876 9 AGE lost on index yrs 90	
10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 11 DE KIND OF BUSINESS OR INDUSTRY Housewife		12 BIRTHPLACE (County & State or foreign country) Maryland 13 COUNTRY OF BIRTH U.S.A.	
14 FATHER'S NAME John D. Markley		15 MOTHER'S MAIDEN NAME Elizabeth Obigs	
16 WAS DECEASED EVER IN ARMED SERVICES (Yes, no, or unknown) (If yes give war or dates of service) NO		17 SOCIAL SECURITY NO 210-32-1511	
18 NAME OF INFORMANT Mrs HESSIE FLOWERS		19 ADDRESS Box 663-9 Glen Arm Md.	
18a CAUSE OF DEATH (Enter only one cause per line for a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z) PART DEATH WAS CAUSED BY Acute pancreatitis IMMEDIATE CAUSE 5 7 10 DUE TO Conditions, if any, which gave rise to immediate cause, a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z NOTING THE UNDERLYING CAUSE Arteriosclerotic cardiovascular disease.		18b EVALUATION BETWEEN ONSET AND DEATH	
19a OTHER SIGNIFICANT CONDITIONS OR RIGORING TO DEATH OR NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN 18a Arteriosclerotic cardiovascular disease.		19b WAS AUTOPSY PERFORMED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a INJURY OR DISEASE (If either NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OR DISEASE (Later nature of injury in Part II of item B) 20c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d CITY, STATE, AND COUNTRY		20e INJURY OR DISEASE (If either NOTIFY MEDICAL EXAMINER) 20f DESCRIBE HOW INJURY OR DISEASE (Later nature of injury in Part II of item B) 20g PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20h CITY, STATE, AND COUNTRY	
21 I certify that this hospital attended the deceased from June 18, 1967 to June 18, 1967 that we last saw the deceased alive on June 18, 1967 and that death occurred at 6:15 PM on June 18, 1967 at the date stated above		22a SIGNATURE H.S. Cockburn, M.D.	
22b PHYSICIAN'S NAME H.S. Cockburn, M.D.		22c ADDRESS 7620 York Rd., Towson, Md. 21204	
23a INITIAL INFORMATION REMOVED, SPECIFY trial		23b DATE THEREOF 6-21-1967	
23c NAME OF FUNERAL HOME OR CEMETERY Markwood Cemetery		23d LOCATION (City or town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Charles J. Jones		25a RECEIVED BY REGISTRAR DATE JUN 21 1967	
25b REGISTRAR SIGNATURE Charles J. Jones		25c REGISTRAR NAME Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07745 **07727**

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk**
c. LENGTH OF STAY (if in hospital, give street address) **2 1/2 Years**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **2023 Ormand Road**

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk**

3. NAME OF DECEASED (Type or print)
First **Joseph** Middle **Fackett** Last **Fackett**

4. DATE OF DEATH
Month **June** Day **15** Year **1967**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **9/25/79** 9. AGE (in years, last birthday) **87** 10. FINDER YEAR OF UNDER 24 HRS. Months Days Hours Min.

11. BIRTHPLACE (County & State, or foreign country) **Czechoslovakia** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Not Known** 14. MOTHER'S MAIDEN NAME **Not Known**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **213-07-4595** 17. INFORMANT (Son) **Joseph Fackett, 2 Oak Road, Edgemere, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Cancer of lung**
(b) **Atherosclerosis of arteries with**
(c) **gangrene of foot**
Deductions, if any which gave rise to immediate cause (a), stating the underlying cause as (b) **due to** (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIOING WITH PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour **19** 20d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)

21. I certify that (1) (this hospital) attended the deceased from **1960 to June, 1967**, that (2) (we) last saw the deceased alive on **6-17-67**, 19**66**, and that death occurred at **6:00** M, from the causes and on the date stated above.

22a. SIGNATURE **B. W. Sollod** 22b. DATE SIGNED **6/15/67**

22c. PHYSICIAN'S NAME (Type) **B. W. Sollod** 22d. ADDRESS **M. D. 2900 Dunran Rd. Dundalk, Md. 21222**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **6/17/67** 23c. NAME OF CEMETERY OR CREMATORY **Sacred Heart of Mary Cem.** 23d. LOCATION (City, town or county) (State) **Baltimore, Maryland**

24. FUNERAL DIRECTOR **John J. Duda** 24b. ADDRESS **7922 Wise Ave. Dundalk, Md.** 25a. REC'D BY REG. STRAR **JUN 19 1967** 25b. REG. STRAR'S SIGNATURE **Charles Judge**





TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tab on top of page 2 and 3 should be filed with the State Dept. of Health prior to burial or cremation or removal, and no any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07747

CERTIFICATE OF DEATH

07729

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Catonsville c RURAL ROUTE & BOX NO. 13 days		2 USUAL RESIDENCE (Where deceased lived, if month long. Resident in before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN Baltimore	
3 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) SPRING GROVE STATE HOSPITAL		4 5 REF. ADDRESS 2006 Wilhelm Street	
6 NAME OF DECEASED (Type or print) First Lillian Middle Mae Last Finch		7 DATE OF DEATH Month June Day 27 Year 1967	
8 SEX female COLOR OR RACE white		9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a 10b DATE OF BIRTH Sept. 25, 1898		11 AGE 68 years 68 months 68 days 68 hours 68 minutes	
12a 12b 12c 12d 12e 12f 12g 12h 12i 12j 12k 12l 12m 12n 12o 12p 12q 12r 12s 12t 12u 12v 12w 12x 12y 12z		13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100	
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Antonia	
15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE "a" Myocardial Infarction, acute, death DUE TO CONDITIONS, any which gave rise to immediate cause "a" stating the underlying cause last Arteriosclerotic cardiovascular ht. dis. DUE TO Arteriosclerosis, generalized, senile		19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100		35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100	
36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07748

CERTIFICATE OF DEATH

07730

PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) b. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town) Owings Mills		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		d. STREET ADDRESS 3501 St. Paul St.	
3. NAME OF DECEASED First Middle Last Roxanne - FISHER		4. DATE OF DEATH Month Day Year 6 7 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-48
9. AGE in years last birthday 18 yrs		10. IF UNDER 1 YEAR Month Day Hour Min 18	
11. IS A PATIENT? Give kind of work done during last 7 days of working life even if retired Dependent		12. KIND OF BUSINESS OR INDUSTRY none	
13. FATHER'S NAME Harold Fisher		14. MOTHER'S MAIDEN NAME Rose E. L. Dodd	
15. WAS DECEASED EVER IN "ARMED FORCES"? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SERVICE, SERVICE NO none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: DEATH WAS CAUSED BY IMMEDIATE ADJUST TO Acute Aspirational Pneumonia & Bronchial Obstruction		INTERVAL BETWEEN ONSET AND DEATH 3 days	
CONDITIONS, if any, which gave rise to immediate cause or slowing the underlying cause (b) Gastro-duodenal dilatation, marked, and ligament of Treitz		Years	
DUO TO 4 Duodenal obstruction by vertebral column		Years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) Quadriplegia with marked kyphoscoliosis - years		TO WHAT TOPOGRAPHY PERMANENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF FATHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month Day Year Hour:am p.m. 5-15 9 53		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f. CITY OR TOWN (County) (State)	
21. I certify that (this hospital) attended the deceased from 5-15 9 53 to 6-7 1967 that we last saw the deceased alive on 6-7 9 67 and that death occurred at 6:10 PM from causes and on the date stated above		22b. DATE SIGNED 6-7-67	
22a. SIGNATURE Richard A. Jones, M.D.		22c. ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a. BURIAL, REMATION, REMOVAL Specify Cremation	23b. DATE HEATED June 9, 1967	23c. NAME OF FIRMERY OR CREMATORY Fort Lincoln Crematory	23d. LOCATION City or town (County) (State) Washington 18, D.C.
24. FUNERAL DIRECTOR H. J. Eckhardt Owings Mills, Md.		25a. REC'D BY REGISTRAR JUN 9 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 5, Page 1, and 2 should be filed with the State Dept of Health prior to burial, cremation or removal and any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

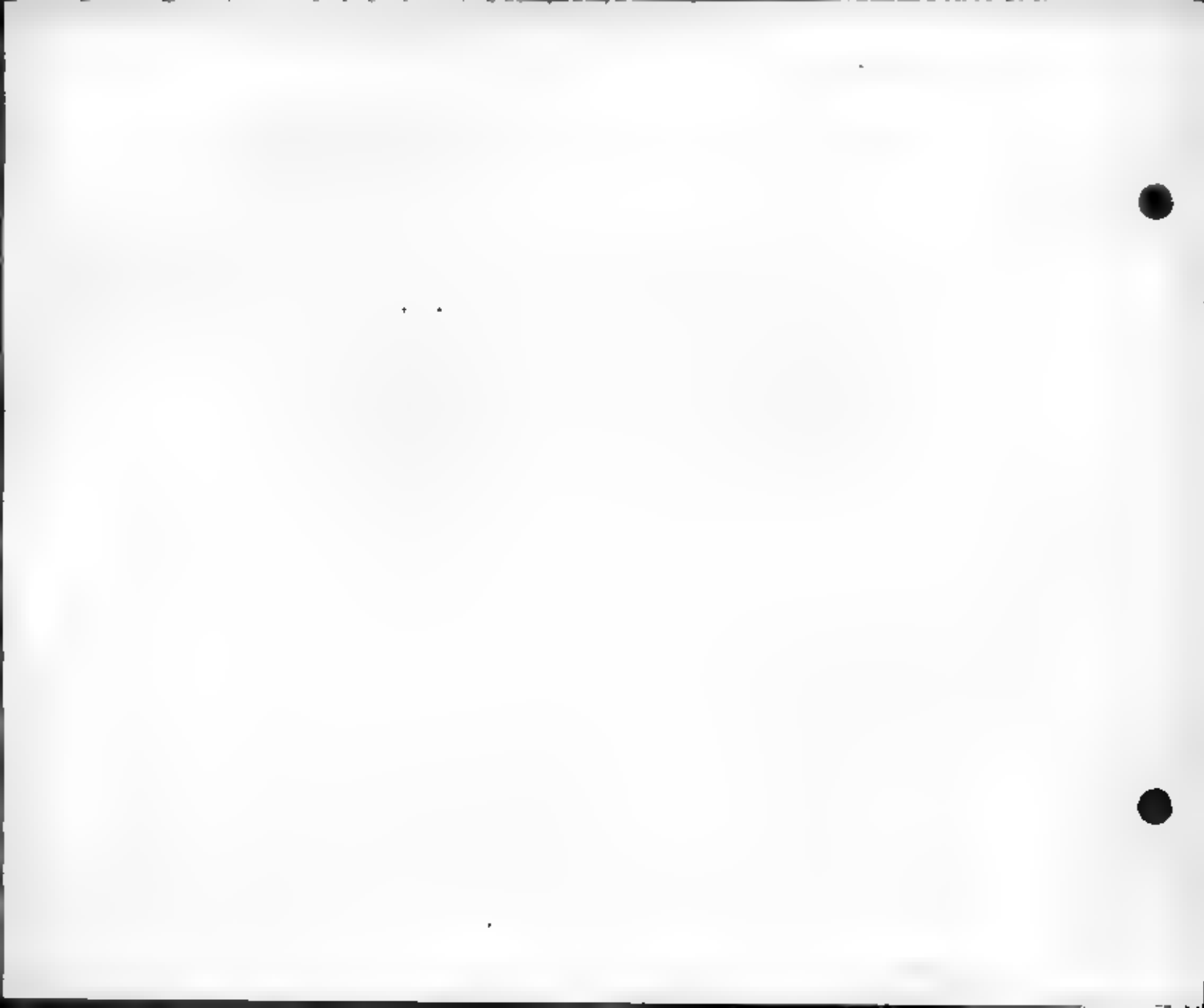
CERTIFICATE OF DEATH

37731

PLACE OF DEATH a. COUNTY Baltimore		b. STATE MARYLAND		c. USUAL RESIDENCE (Where deceased lived if instit. on residence before admission: a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Catonsville		c. ENGINE OF STATE N. b.		d. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address Spring Grove State Hospital		e. STREET ADDRESS 2600 Canterbury Road		f. BY RESISTANCE ON A FORM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Last or initials) Artis J. Fissel		4. DATE OF DEATH Month June Day 1 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 5, 1865		9. AGE in years 101		10. IF UNDER 1 YEAR OF AGE, Give Month, Day, Hour, Min.	
11a. PLACE OF BIRTH (Give kind of work done during most of working life, even if retired) Retired		11b. KIND OF BUSINESS OR INDUSTRY Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Fissel		14. MOTHER'S MAIDEN NAME Katherine Allison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-20-5047		17. INFORMANT State Records: Spring Grove/Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA DUE TO ANTERIOR SCURVY, ARTERIAL DIS. V.S. DUE TO ARTERIAL DIS. V.S.		18b. INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? IF EITHER, NOTIFY MEDICAL EXAMINER.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)			
20c. TIME OF INJURY Month, Day, Year Hour, min, pm		20d. INJURY OCCURRED Whole <input type="checkbox"/> Not Whole <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from Feb. 21, 1967 to JUNE 1 1967 that (1)(X) we, I, saw the deceased alive on 19 and that death occurred at M. from causes and on the date stated above		22a. SIGNATURE E. J. Fissel		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME Type E. J. Fissel		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE INTERIOR 6/5/67		23c. NAME OF CEMETERY OR CREMATORY Jefferson Cem.	
23d. LOCATION (City or Town) (County) (State) Jefferson, Pa.		24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.		25a. RECEIVED BY REGISTRAR DATE JUN 5 1967	
25b. REGISTRAR'S SIGNATURE 25b					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial transit permit. Then please remove urban papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial. A permit for removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place the certificate, pages 1 and 2, in the funeral home papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy given to the family within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE MARYLAND 21201
Item # 1a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z

CERTIFICATE OF DEATH

07750

07732

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF TAY IN b. 21221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		4 STREET ADDRESS Apt. 2B Mars Road	
3 NAME OF DECEASED (Type or print) MARY FITZ		4 DATE OF DEATH June 16, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/7/97
9 AGE In years, last birthday 70		10 IF UNDER YEAR 70	
11a. INDUSTRY OR OCCUPATION (Give kind of work done during most or working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (County, State or foreign country) Pennsylvania		13 IT TEN OF WHAT COUNTRY? USA	
14 FATHER NAME		15 MOTHER MAIDEN NAME	
16 DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17 LOCAL IDENTITY NO	
18 INFORMANT ST. JOSEPH HOSP		Address	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the lung with metastases DUE TO (b) Congestive heart failure DUE TO (c) 		20 INTRACRANIAL PRESSURE ONSET AND DATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I		21 WAS A TOPOGRAPHY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. A. DEATH UNDER VIOLENCE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II a. item 19)	
23a. TIME OF INJURY Month Day Year 19		23b. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. CITY OR TOWN Towson County Baltimore State Md.	
24 I certify that the (th) hospital attended the deceased from June 14, 1967 to June 16, 1967 and that death occurred on June 16, 1967 from causes and on the date stated above.		25 SIGNATURE Ramon P. Lopez MD	
26 PHYSICIAN NAME Ramon P. Lopez		27 DATE SIGNED June 16, 1967	
28 BIRTH REMOVAL REMOVED		29 DATE OF BIRTH 7	
30 NAME OF THE FRY OR CREMATORY varian of Faith		31 LOCAL IDENTITY NO (County) (State) Baltimore, Md.	
32 FUNERAL DIRECTOR		33 ADDRESS	
34 R-ED BY REGISTRAR DAUN 21 1967		35 REGISTRAR SIGNATURE Charles Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07751

CERTIFICATE OF DEATH

07733

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if in foreign residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN <u>Quinns Mills</u> outside corporate limits write RURAL and give nearest town		c LENGTH OF STAY IN b <u>6/18/65</u>	
3 NAME OF HOSPITAL OR INSTITUTION <u>Rosewood State Hospital</u>		d ADDRESS <u>92 Cooks Lane</u>	
4 NAME OF DECEASED <u>Elizabeth Marie Fitzgerald</u>		5 DATE OF DEATH <u>June 21 1967</u>	
6 SEX <u>Female</u> <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <u>8/3/56</u>		9 AGE <u>10</u> years <u>10</u> months <u>10</u> days	
10a IS THIS DECEASED <u>Dependent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11a IS THIS DECEASED <u>Dependent</u>		11b BIRTHPLACE <u>Baltimore, Md.</u>	
12 NAME <u>James Joseph Fitzgerald</u>		13 NAME <u>Maeie Cinguegran</u>	
14a ADDRESS <u>Rosewood Records, Quinns Mills, Md.</u>		14b ADDRESS <u>Rosewood Records, Quinns Mills, Md.</u>	
15a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAY CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetes Coma</u> DUE TO (b) <u>Known Diabetes</u> DUE TO (c) <u>Long Abuse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>1 yr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Orthostatic Pneumonia bilateral</u>		WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ALL DEATH WAS INDUCED BY <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month Day Year <u>6-18 1965</u>		20d INJURY OCCURRED <u>While at work</u>	
20e PLACE OF INJURY Home Farm factory street office bldg. etc. <u>Home</u>		20f (City or town) County State <u>Baltimore, Md.</u>	
21 I certify that (this hospital) attended the deceased from <u>6-18 1965</u> to <u>6-21 1967</u> that (I) (we) last saw the deceased alive on <u>6-21 1967</u> and that death occurred at <u>7:00 PM</u> from causes and on the date stated above			
22a SIGNATURE <u>Richard A. Jones</u>		22b DATE SIGNED <u>22 June 67</u>	
22c PHYSICIAN'S NAME (Type) <u>Richard A. Jones, M.D.</u>		22d ADDRESS <u>Rosewood St. Hosp., Quinns Mills, Md.</u>	
23a BURIAL INFORMATION <u>Buried</u>		23b DATE OF BURIAL <u>6/26/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d LOCATION (City or town) County (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRETOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a REF'D BY REGISTRAR <u>JUN 26 1967</u>	
25b REGISTRAR'S SIGNATURE <u>John A. Dargatzis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in, please remove page 5 and 2 and page 3 should be detached for use as the burial-transit permit. The please remove page 5 and 2 and page 3 should be filed with the State Dept. at 301 W Preston Street, Baltimore, Md. 21201.



FOR STATE
HEALTH DEPT.

This certificate should be executed with 24 hours after death. It is necessary to have the certificate written by the person in item 8. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR Page 3 should be used as a burial permit, permit five pages and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours of death.

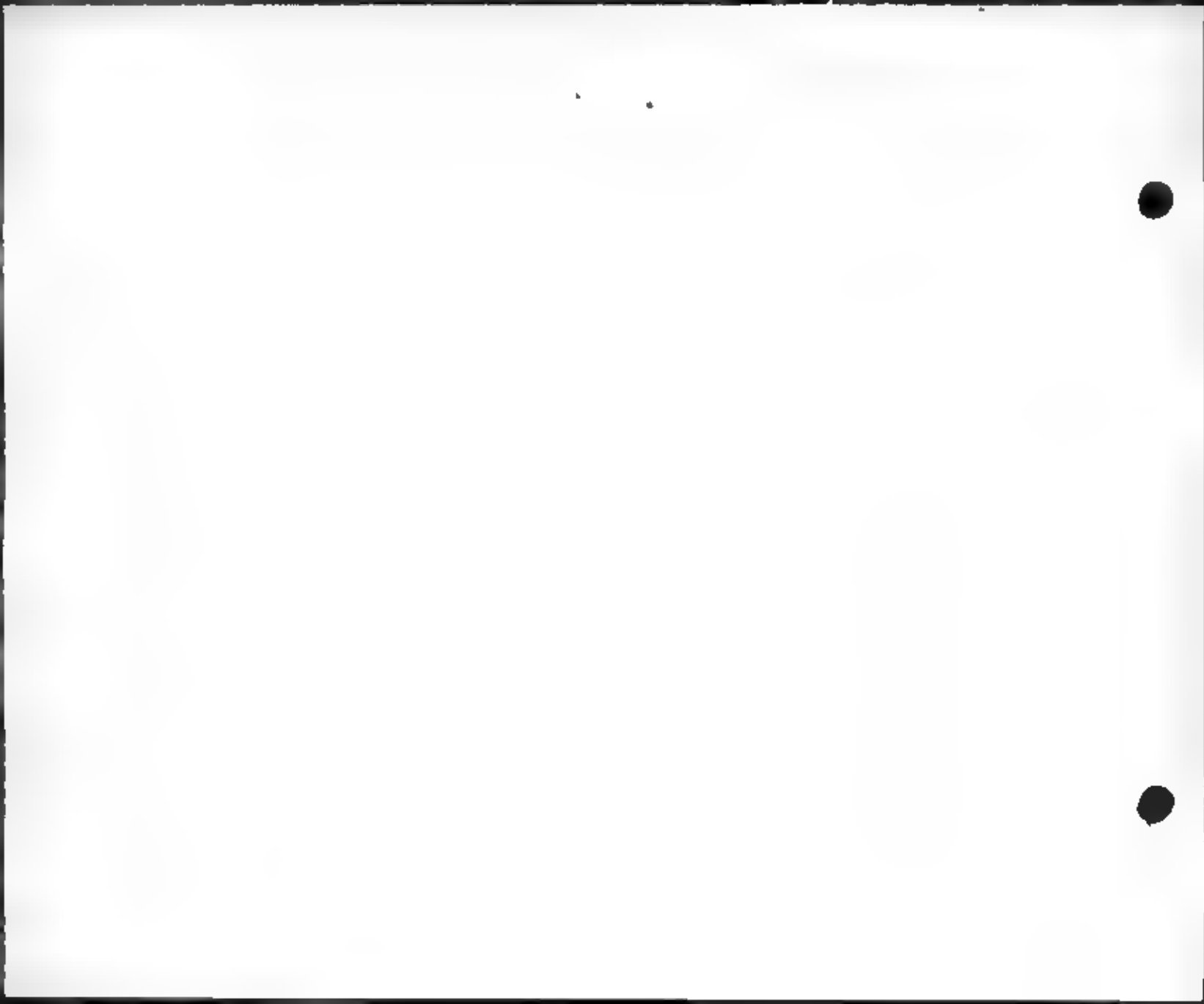
TO DEPUTY MEDICAL EXAMINER

VR A 5ME 15
6M 166

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27752 PLACE OF DEATH Baltimore		27734 USUAL RESIDENCE When deceased resided in Residence before death Md. Balto.	
Ransallstown		Granite	
8600 block Liberty Rd.		Bunker Hill Rd.	
NAME OF DECEASED James H. Floyd		DATE OF DEATH June 27 1967	
Male Colored		BIRTH DATE 1904	
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BIRTHPLACE U.S.A.	
3 OTHER NAME		4 MOTHER A'DEN NAME	
5 WORKER IN DEPT. OF HEALTH		6 CERTIFICATE NO.	
7 CAUSE OF DEATH 44-5X Cardiac Decompensation Hypertensive Arteriosclerotic C-V Disease		8 AGE 4 yrs.	
9 PART II OTHER SIGNIFICANT CONDITIONS Chronic Alcoholism		10 DATE OF DEATH June 27 1967	
11 PRIMARY CAUSE OF DEATH none		12 SECONDARY CAUSE OF DEATH none	
13 TIME OF DEATH none		14 INQUIRY <input checked="" type="checkbox"/> INSPECTION <input checked="" type="checkbox"/>	
15 I certify that I took charge of the remains after being held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		16 DATE SIGNED 6-28-67	
17 ACTUAL SIGNATURE D. D. Caples		18 ASSISTANT MEDICAL EXAMINER	
19 EXAMINER'S NAME D. D. Caples, M. D.		20 ADDRESS 6 Hanover Rd., Reisterstown, Md.	
21 23a SUPPL. REMARKS		22 23b DATE TIME OF	
23c FUNERAL DIRECTOR		24 25a BY REGISTRAR	
25b REGISTRAR SIGNATURE		DATE JUN 30 1967	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W PRESTON STREET BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07753

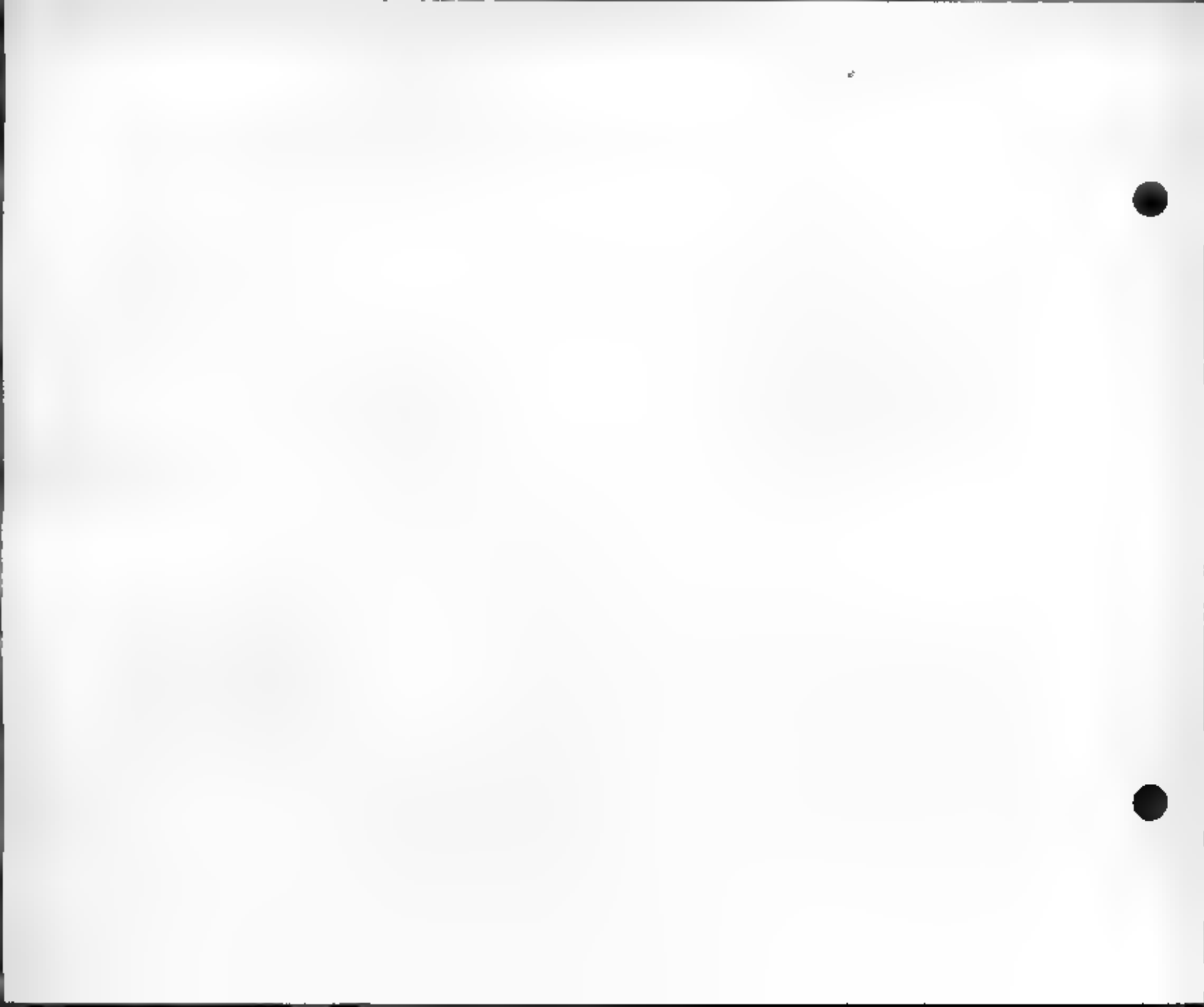
07735

PLACE OF BIRTH BALTO		JULIA RESIDENCE MD	
MIDDLE RIVER		BALTO	
MARTINS LACON		Essex	
NAME OF DECEASED LARRY T. FLOYD		DATE OF DEATH June 4, 1967	
MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF BIRTH Sept 29-1950	
MOTHER'S NAME GRADY FLOYD		FATHER'S NAME JARRELL	
CAUSE OF DEATH 129x		MANNER OF DEATH Drowning	
CONDITIONS IF ANY, WHICH GAVE RISE TO THE UNDERLYING CAUSE 145-6-4-67		MANNER OF DEATH 145-6-4-67	
I certify that this is a true and correct copy of the original as shown to me by the medical examiner.		I certify that this is a true and correct copy of the original as shown to me by the medical examiner.	
ACTUAL SIGNATURE M. B. DAYIS		DATE SIGNED 6/9/67	
EXAMINER'S NAME (Type) M. B. DAYIS		DATE SIGNED 6/9/67	
BURIAL OR CREMATION BURIAL		DATE SIGNED 6/9/67	
NAME OF BURIAL OR CREMATION J. G. Connelly Sons		DATE SIGNED 6/9/67	
ADDRESS OF BURIAL OR CREMATION Essex MD		DATE SIGNED 6/9/67	

TO DEPUTY MEDICAL EXAMINER. The certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR. The certificate should be filed in the State Department of Health and in any event within 72 hours after death.

Health Department of Maryland, Baltimore, Maryland.



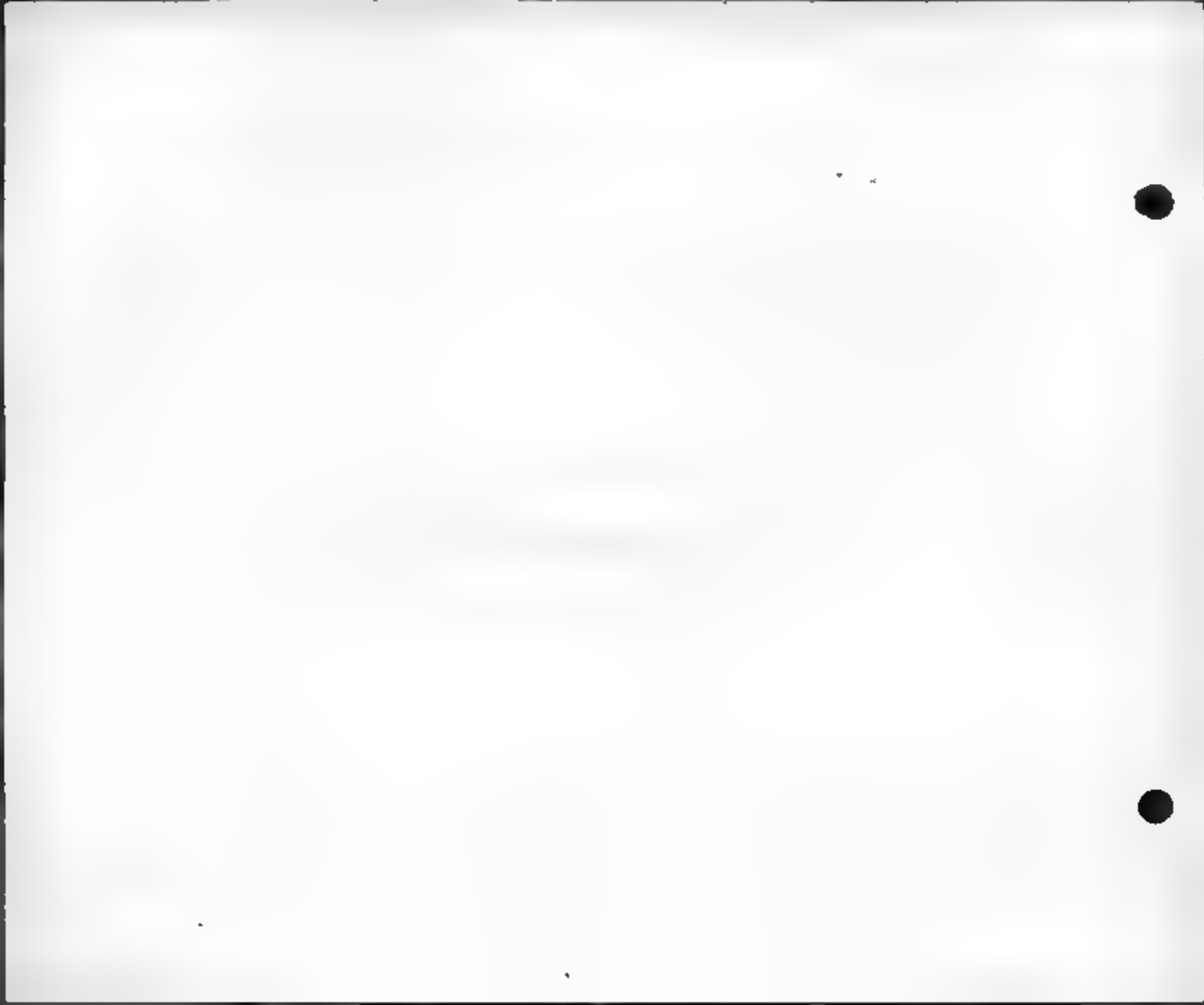


CERTIFICATE OF DEATH

07755

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Towson		2 USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY	
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		d. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 21212	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		f. STREET ADDRESS 1402 Limit Ave.	
3 NAME OF DECEASED a. First Irene b. Middle FOLTZER c. Last FOLTZER		4 DATE OF DEATH Month June Day 2 Year 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 18, 1890
9 AGE (In years, months, days, hours, minutes) 76		10 BIRTHPLACE (County & State or foreign country) Maryland	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12 IN WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Jacob Rice		14 MOTHER'S MAIDEN NAME Louise Atkin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes or no, if unknown) no		16 SOCIAL SECURITY NO.	
17 INFORMANT Mr. Alois B. Zetneisl		Address same	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE: Recurrent Brain infarction CONDITIONS (any, which gave rise to immediate cause, affecting the underlying cause) a. DU TO b. DU TO c. (c)			19 INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Generalized arteriosclerosis.			20 WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ALL DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		21b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
22a TIME OF INJURY Month Day Year Hour a.m. p.m.	22b INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	22c PLACE OF INJURY Home farm factory street, office bldg, etc.	22d (City or town) (County) (State)
23 I certify that St. Josephs Hospital , attended the deceased from May 30 1967 to June 2 1967 that we saw the deceased on June 2 1967 and that death occurred at 4:42 M from causes and on the date stated above			
24a SIGNATURE Reynaldo Ortuels-Gomez, M.D.		24b DATE SIGNED June 2, 1967	
24c PHYSICIAN'S NAME (Type)		24d ADDRESS 7620 York Rd. Towson 21204	
25a BURIAL CREMATION, REMOVAL (Specify)	25b DATE THEREOF 6/5/67	25c NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	25d LOCATION (City or Town) (County) (State) Baltes., Md.
26 FUNERAL DIRECTOR Leonard J. Ruck Inc.		26a REL'D BY REGISTRAR JUN 5 1967	
26b ADDRESS Baltes., Md.		26c REGISTRAR'S SIGNATURE John J. George	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript, permit the please remove urban papers, pages and show it be filed with the State Dept of Health prior to burial, cremation or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached to use as the burial-transit permit. The funeral director should be filed with the State Dept of Health put in to be in cremation or removal and in 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07756

07733

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" Towson c. NAME OF HOSPITAL OR INSTITUTION: If not in hospital give street address St. Joseph Hospital		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY L 111 c. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town" Baltimore 21220 d. STREET ADDRESS 1423 Third Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Harry M. Foote Sr. SEX male COLOR OR RACE white 4 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 5 DATE OF BIRTH 7-18-04 6 AGE 62 years last birthday 7 FINDER: YEAR 1967 Months 1 Days 10 Hours 67		8 DATE OF DEATH June 1 1967 9 AGI 62 years last birthday 10 FINDER: YEAR 1967 Months 1 Days 10 Hours 67	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 12 KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal 13 BIRTHPLACE (Country & State or foreign country) MD. 14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 FATHER'S NAME HAROLD FOOTE 16 MOTHER'S MAIDEN NAME ANNIE BURKHARDT	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or date of service) NO 18 SOCIAL SECURITY NO. 4-4-03 344 19 INFORMANT CAITLIN FOOTE Address ALBANY		20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ruptured arteriosclerotic aneurysm of descending DUE TO portion of Thoracic Aorta into the right pleural cavity. Conditions, if any, which gave rise to immediate cause (a), (b), or (c): shooting the underlying cause lost	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER 21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.) 21c. TIME OF INJURY Month Day Year May 10 1967 Hour a.m. 5PM p.m. 21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work 21e. PLACE OF INJURY Home farm factory, street, office bldg., etc. 21f. (City or town) (County) (State)		22. I certify that I (this hospital) attended the deceased from May 10 1967 to June 1 1967 that I saw the deceased alive on June 1 1967 and that death occurred at 5PM M. from causes and on the date stated above	
22a. SIGNATURE Joana S. Cockburn M.D. 22b. PHYSICIAN'S NAME (Type) Joana S. Cockburn, M.D. 22c. ADDRESS 7620 York Rd. Baltimore, Md. 21204		22d. DATE SIGNED June 2, 1967 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/10	23c. NAME OF CEMETERY OR CREMATORY W. OFF. A.P.	23d. LOCATION (City or Town) (County) (State) ALBANY
24. FUNERAL DIRECTOR T. S. CRANE ADDRESS 3 E. MAIDEN		25a. REC'D BY REGISTRAR DALE 25b. REGISTRAR'S SIGNATURE Charles Young	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate within the word pending in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 has the name of the physician. Marked Examiners fill in 3 with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VE A 5ME 51
6M /67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77757		67739	
PLACE OF DEATH Baltimore		JULIA, RESIDENCE Maryland	
Dundalk		Baltimore	
16 years		Dundalk	
1306 Willow Road		1306 Willow Road	
NAME OF DECEASED Charles D. Foster Sr.		DATE OF DEATH June 23 1967	
Male	White	1/8/08	59
Industrial Engineer		North Carolina	
Capas W. Foster		Catherine Ludwig	
No		Mrs. Ruby Foster, 1306 Willow Rd. Dundalk	
CAUSE OF DEATH Acute Coronary occlusion		A.C.H.D.	
2. I certify that death resulted from: Natural causes		Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Theodore C. Patterson		DATE SIGNED 6/23/67	
EXAMINER'S NAME Theodore C. Patterson		ADDRESS 105 Main St. Dundalk, Md. 21222	
Burial 6/26/67		Oak Lawn Cemetery Baltimore, Md.	
John J. Duda, 7922 Wise Ave. Dundalk, Md.		JUN 27 1967 Charles Judge	



TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours of the death and necessary please execute the certificate within the word pending in pencil. Item 18 Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages and 2 with the State Department of Health for its designated non-cremation burial. Cremation is permitted by the State Department of Health.

TO DEPUTY MEDICAL EXAMINER

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages and two of the State Department of Health or its designated agent prior a burial, cremation or removal and, in one event, within 7 hours after death.

0.000000

FR 2 124F 16
624 1 56

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH OF a. COUNTY Baltimore		b. STATE Maryland	
b. OR TOWN Garrison		c. TOWN Baltimore	
c. NAME OF DECEASED Anna Fox		d. DATE OF DEATH June 19 1967	
e. PLACE OF DEATH Foxleigh Nursing Home		f. ADDRESS 1504 N. Pulaski Street	
g. SEX Female		h. RACE White	
i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		j. DATE OF BIRTH 86	
k. OCCUPATION Housewife		l. BIRTHPLACE Lithuania	
m. FATHER'S NAME ?		n. MOTHER'S MAIDEN NAME Unknown	
o. CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease		p. DATE OF DEATH June 19 1967	
q. OTHER SIGNIFICANT CONDITIONS none		r. DATE OF DEATH June 19 1967	
s. PLACE OF DEATH none		t. DATE OF DEATH June 19 1967	
u. PLACE OF DEATH none		v. DATE OF DEATH June 19 1967	
w. PLACE OF DEATH none		x. DATE OF DEATH June 19 1967	
y. PLACE OF DEATH none		z. DATE OF DEATH June 19 1967	
aa. PLACE OF DEATH none		ab. DATE OF DEATH June 19 1967	
ac. PLACE OF DEATH none		ad. DATE OF DEATH June 19 1967	
ae. PLACE OF DEATH none		af. DATE OF DEATH June 19 1967	
ag. PLACE OF DEATH none		ah. DATE OF DEATH June 19 1967	
ai. PLACE OF DEATH none		aj. DATE OF DEATH June 19 1967	
ak. PLACE OF DEATH none		al. DATE OF DEATH June 19 1967	
am. PLACE OF DEATH none		an. DATE OF DEATH June 19 1967	
ao. PLACE OF DEATH none		ap. DATE OF DEATH June 19 1967	
aq. PLACE OF DEATH none		ar. DATE OF DEATH June 19 1967	
as. PLACE OF DEATH none		at. DATE OF DEATH June 19 1967	
au. PLACE OF DEATH none		av. DATE OF DEATH June 19 1967	
aw. PLACE OF DEATH none		ax. DATE OF DEATH June 19 1967	
ay. PLACE OF DEATH none		az. DATE OF DEATH June 19 1967	
ba. PLACE OF DEATH none		bb. DATE OF DEATH June 19 1967	
bc. PLACE OF DEATH none		bd. DATE OF DEATH June 19 1967	
be. PLACE OF DEATH none		bf. DATE OF DEATH June 19 1967	
bg. PLACE OF DEATH none		bh. DATE OF DEATH June 19 1967	
bi. PLACE OF DEATH none		bj. DATE OF DEATH June 19 1967	
bk. PLACE OF DEATH none		bl. DATE OF DEATH June 19 1967	
bm. PLACE OF DEATH none		bn. DATE OF DEATH June 19 1967	
bo. PLACE OF DEATH none		bp. DATE OF DEATH June 19 1967	
bq. PLACE OF DEATH none		br. DATE OF DEATH June 19 1967	
bs. PLACE OF DEATH none		bt. DATE OF DEATH June 19 1967	
bu. PLACE OF DEATH none		bv. DATE OF DEATH June 19 1967	
bw. PLACE OF DEATH none		bx. DATE OF DEATH June 19 1967	
by. PLACE OF DEATH none		bz. DATE OF DEATH June 19 1967	
ca. PLACE OF DEATH none		cb. DATE OF DEATH June 19 1967	
cc. PLACE OF DEATH none		cd. DATE OF DEATH June 19 1967	
ce. PLACE OF DEATH none		cf. DATE OF DEATH June 19 1967	
cg. PLACE OF DEATH none		ch. DATE OF DEATH June 19 1967	
ci. PLACE OF DEATH none		cj. DATE OF DEATH June 19 1967	
ck. PLACE OF DEATH none		cl. DATE OF DEATH June 19 1967	
cm. PLACE OF DEATH none		cn. DATE OF DEATH June 19 1967	
co. PLACE OF DEATH none		cp. DATE OF DEATH June 19 1967	
cq. PLACE OF DEATH none		cr. DATE OF DEATH June 19 1967	
cs. PLACE OF DEATH none		ct. DATE OF DEATH June 19 1967	
cu. PLACE OF DEATH none		cv. DATE OF DEATH June 19 1967	
cw. PLACE OF DEATH none		cx. DATE OF DEATH June 19 1967	
cy. PLACE OF DEATH none		cz. DATE OF DEATH June 19 1967	
da. PLACE OF DEATH none		db. DATE OF DEATH June 19 1967	
dc. PLACE OF DEATH none		dd. DATE OF DEATH June 19 1967	
de. PLACE OF DEATH none		de. DATE OF DEATH June 19 1967	
df. PLACE OF DEATH none		df. DATE OF DEATH June 19 1967	
dg. PLACE OF DEATH none		dg. DATE OF DEATH June 19 1967	
dh. PLACE OF DEATH none		dh. DATE OF DEATH June 19 1967	
di. PLACE OF DEATH none		di. DATE OF DEATH June 19 1967	
dj. PLACE OF DEATH none		dj. DATE OF DEATH June 19 1967	
dk. PLACE OF DEATH none		dk. DATE OF DEATH June 19 1967	
dl. PLACE OF DEATH none		dl. DATE OF DEATH June 19 1967	
dm. PLACE OF DEATH none			

22 DATE SIGNED

6-19-67

JUN 23 1967



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07753

CERTIFICATE OF DEATH

07741

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bradshaw c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bradshaw Road		2 USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Adams c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bradshaw (Rural) d. STREET ADDRESS Bradshaw Road Bradshaw Md	
3 NAME OF DECEASED (Type or print) Oscar		4 DATE OF DEATH Month 6 Day 30 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIAGE STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-4-1880
9 AGE (In years, last birthday) 87		10 IF UNDER 1 YEAR Months 30 Days 15 Hours 4	
11 OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12 KIND OF BUSINESS OR INDUSTRY Self-employed	
13 FATHER'S NAME Joseph Frank		14 MOTHER'S MARRIED NAME Mary Schwartz	
15 DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 108-123456789	
17 INFORMANT Mrs Elizabeth Streett Bradshaw Road		18 ADDRESS Bradshaw Road	
19 CAUSE OF DEATH (Enter only one cause per line, a, b, and c) PART I: DEATH CAUSED BY IMMEDIATE CAUSE (a) CONDITIONS, if any, which gave rise to immediate cause, a, stating the underlying cause last b c		20 Cerebral Hemorrhage Arteriosclerotic Cardiovas. Dis.	
21 PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None		22 WA AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a AL DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
24 TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		25 INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> a work <input type="checkbox"/>	
26 PLACE OF INJURY (Home, farm, factory, street, office, building, etc.)		27 (City or town) (County) (State)	
28 I certify that (I) (this hospital) attended the deceased from May 6, 1967 to June 30, 1967 that (s) (we) last saw the deceased alive on June 29, 1967 and that death occurred 10:50 AM from causes and on the date stated above			
29a SIGNATURE OF PHYSICIAN Clifford F. Hudson		29b MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
30 PHYSICIAN'S NAME (Type or print) CLIFFORD F. HUDSON		31 ADDRESS PERK, MD	
32a BURIAL, CREMATION, REMOVAL (Specify)	32b DATE THEREOF 7-3-1967	32c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	32d LOCATION (City or town) (County) (State) Baltimore Md.
33 FUNERAL DIRECTOR Kearney Funeral Home		34 ADDRESS 7401 Belair Road	
35 REG. BY REGISTRAR 10		36 REGISTRAR'S SIGNATURE John A. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the certificate to the State Department of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation or removal, and a copy given to the funeral director.

VR A 5
20 1A

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

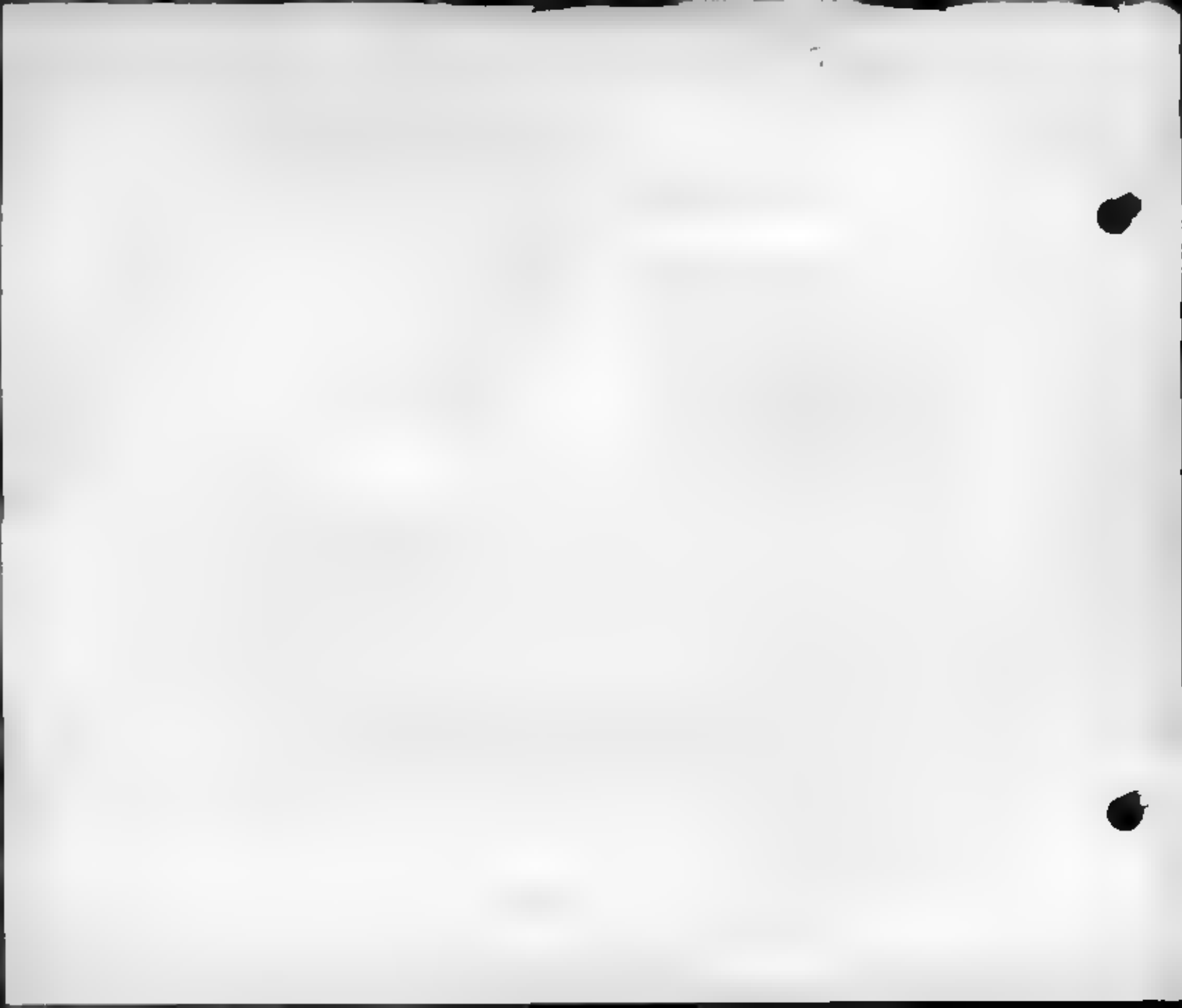
37760

CERTIFICATE OF DEATH

07712

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write R.R. and give nearest town) Bowley's Quarters (20) c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 175 Chester Rd. Rt. 15		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write R.R. and give nearest town) Bowley's Quarters (20) d. STREET ADDRESS Box 175 Chester Rd. Rt. 15	
3. NAME OF DECEASED (Type or print) AGNES FRY		4. DATE OF DEATH Month June Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Oct. Day 21 Year 1912
9a. OCCUPATION (Give kind of work done during major part of working life even if retired) waitress		9b. KIND OF BUSINESS OR INDUSTRY Resturant	
10. FATHER'S NAME Kirsch		11. MOTHER'S MAIDEN NAME ?	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		13. SOCIAL SECURITY NO. 210 01 4266	
14. INFORMANT James R. Fry		15. ADDRESS Same	
16. B. CAUSE OF DEATH (Enter only one cause per line for immediate cause and conditions if any which gave rise to immediate cause, stating the underlying cause) Cerebral Hemorrhage and Cancer of mouth			
17. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE GIVEN IN PART I None			
18a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) 19		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I as Part of item B.)	
19a. TIME OF INJURY Month, Day, Year Hour, AM, PM 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. CITY or town (County) (State)	
21. I certify that (this hospital) attended the deceased from May 26, 1967 to June 16, 1967 that (I) (we), last saw the deceased alive on June 15, 1967 and that death occurred at 3:00 PM from causes and on the date stated above			
22a. SIGNATURE Rooney R. Beck		22b. DATE SIGNED 6-16-67	
22c. PHYSICIAN'S NAME (Type) Rooney R. Beck		22d. ADDRESS 901 Fuzellway Apt 202	
23a. BURIAL OR CREMATION (Type) Burial	23b. DATE OF BURIAL OR CREMATION 6/19/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR James E. Prudzinski		25. ADDRESS 1407 Eastern Ave.	
26. RECEIVED BY JUN 19 1967		27. RECEIVED BY James E. Prudzinski	





TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 can be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial or cremation or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

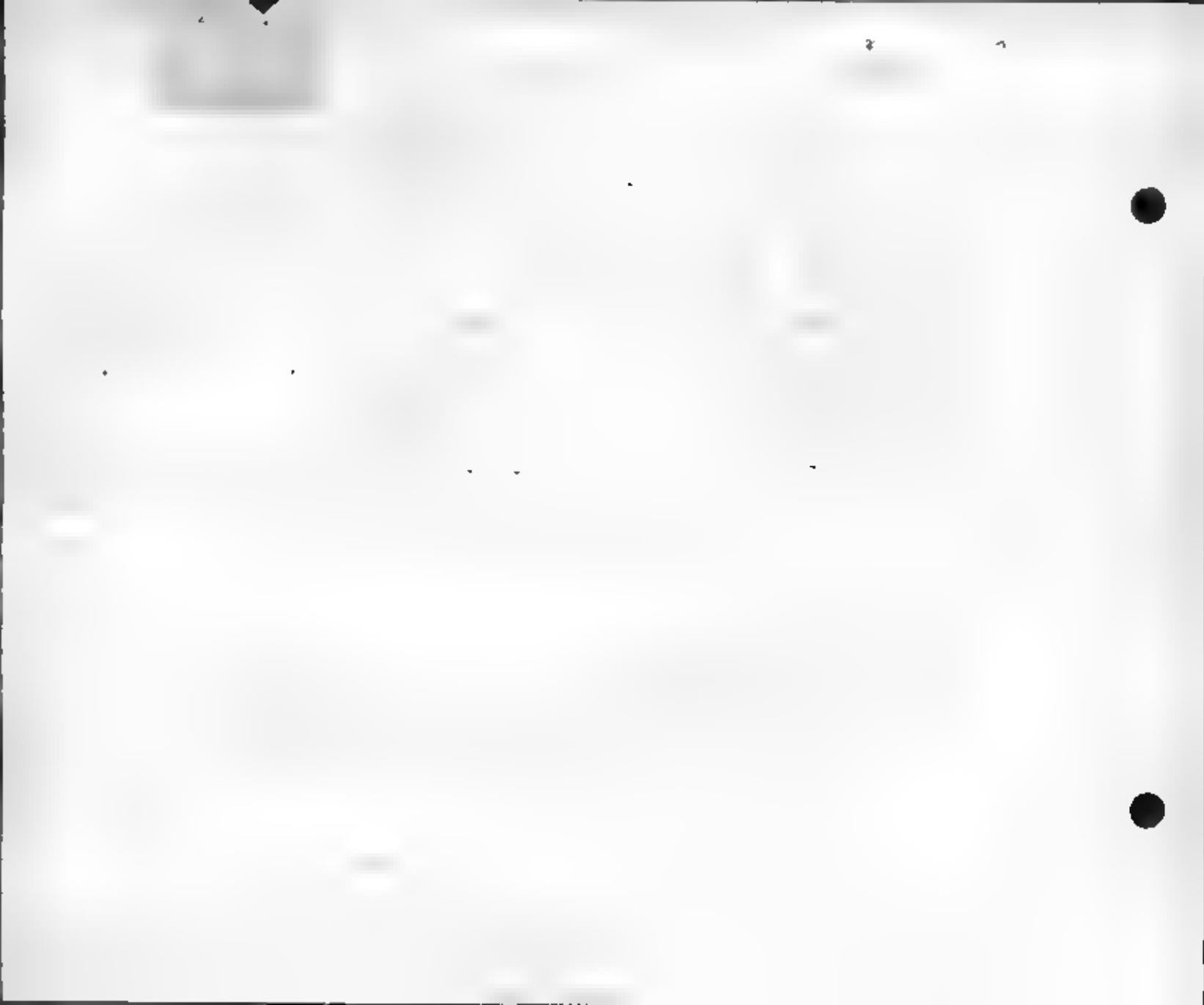
07762

CERTIFICATE OF DEATH

07744

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN FORT HOWARD c STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE MARYLAND b CITY OR TOWN BALTIMORE	
3 NAME OF DECEASED First Middle Last CHARLES NICHOLAS GASTON		4 DATE OF DEATH Month Day Year JUNE 19 1967	
5 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) VETERANS ADMINISTRATION HOSPITAL		6 TRAIL ADDRESS 1925 ST. PAUL STREET	
7 SEX MALE 8 COLOR OR RACE WHITE 9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 10 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 AGE In year last birthday 68 12 BIRTH PLACE (If born in U.S. give State and County) LEWIS COUNTY, W. VIRGINIA U.S.A.	
13 OCCUPATION (Give kind of work done during most or whole life ever or retired) PAINTER		14 KIND OF BUSINESS OR INDUSTRY	
15 FATHER'S NAME THOMAS C. GASTON		16 MOTHER'S NAME NONA NICHOLAS	
17 VA DECEASED DURING SERVICE OR RESERVE Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 18 SOCIAL SECURITY NO 236 16 90 17		19 INFORMANT LENA C. GASTON Address CLIN. REC., VAH, FT. HOWARD, MARYLAND	
20 CAUSE OF DEATH (Enter cause of death as far as possible) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE HEMORRHAGE DUE TO CARCINOMA TONSILAR AREA, LEFT, DUE TO 1 YEAR		21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in Part I) HOLES	
22a INJURY OR DISEASE UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (If other notified medical examiner) HEMORRHAGE		22b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) HEMORRHAGE	
23a TIME OF INJURY Month Day Year June 19 1967		23b TIME OF DEATH Month Day Year June 19 1967	
24a SIGNATURE JORGE A. FABARA, M.D.		24b DATE 6 19 67	
25a BIRTH INFORMATION 25b DATE OF BIRTH 6-22-67		25c NAME OF EMPLOYER OR MATRIMONY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND	
25d REF. BY REGISTRAR Ellsworth Armacost		25e REF. BY REGISTRAR Charles Judge	
25f DATE JUN 21 1967		25g PLACE Baltimore, Md. 21207	

VA 5-5
25-1-67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07763

07715

1 PLACE OF DEATH a COUNTY <u>BALTO</u> MARYLAND		7 USUAL RESIDENCE Where deceased lived 1 month prior to residence before admission a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>CATLINVILLE</u>		c CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>TIMONIA</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>HOUSE IN CARE</u>		d STREET ADDRESS <u>46 TIMONIA RD</u>	
3 NAME OF DECEASED First Middle Initial <u>ELEANOR G. GIARTH</u>		4 DATE OF DEATH Month Day Year <u>JUNE 15 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>3/30/93</u>
9 AGE (in years last birthday) <u>74</u>		10 IF UNDER 1 YEAR Months Days Hours Min <u>74</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life ever if retired) <u>Nurse</u>		12 KIND OF BUSINESS OR INDUSTRY <u>PA</u>	
13 BIRTHPL. (County & State or foreign country) <u>PA</u>		14 IF IN FOREIGN COUNTRY	
15 FATHER'S NAME <u>HARVEY NICKOLLS</u>		16 MOTHER'S MAIDEN NAME <u>EMMA GARRETT</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		18 SOCIAL SECURITY NO <u>21-1110-6121</u>	
19 INFORMANT <u>WILLIAM GIARTH, SON</u>		Address	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I OF II WAS ADDED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>7-1</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions if any which gave rise to immediate cause (c) <u>Arteriosclerotic Cardiovascular Disease</u> stating the underlying cause (d) <u>10-20</u>		19 INTERVIEW BETWEEN ONST. AND DHA <u>1-25</u> <u>3 mo</u> <u>10-20</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		9 INTERVIEW BETWEEN ONST. AND DHA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a IDENTIFYING INTERVIEWING OR OTHER PERSON AGE OF DEATH AT THEIR MOST RECENT EXAMINATION	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a or Part c item 18.)	20c INJURY REPORTED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20d TIME OF INJURY Month Day Year 10:00 am 9	20e PLACE OF INJURY (Home farm, factory, street, etc bldg etc)	20f City or town County State	
21 I certify that this hospital attended the deceased from <u>4-14-67</u> to <u>6-15-67</u> that I (we) last saw the deceased alive on <u>6-12-67</u> and that death occurred at <u>2:20</u> PM on the date stated above			
22a SIGNATURE <u>William H. Gallagher</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>W. H. Gallagher</u>		22d ADDRESS <u>6207 Frederick Ave, Baltimore, 28, Md</u>	
23a I.R.A. AFFILIATION <u>BLAIAI</u>	23b DATE THEREOF <u>6/19/67</u>	23c NAME OF FLETCHER OR REMATORY <u>RESE HILL</u>	23d LOCALITY (City or town) (County) (State) <u>ALTCORN PA</u>
24 FUNERAL DIRECTOR <u>ESR. H. H. ABB</u>		25a RECD BY REGISTRAR <u>JUN 19 1967</u>	
25b REGISTRAR SIGNATURE <u>Charles Judge</u>		25c REGISTRAR SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health or to a local cremation or removal and reinterment within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER

TO FUNERAL DIRECTOR

Rec'd prior to burial registration or removal and if any even within 72 hours after death

37764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07746

PLACE OF BIRTH

Baltimore

USUAL RESIDENCE

Baltimore

NAME OF DECEASED

Patricia

DATE OF DEATH

June 4, 1967

SEX

F

RACE

White

MARRIED

Never married

DATE OF BIRTH

2/3/46

AGE

21

EDUCATION

Bookkeeper

BIRTHPLACE

Maryland

FATHER'S NAME

Kermit Gimmel

MOTHER'S NAME

Margaret Dowd

US ARMY

No

INFORMANT

James H. Gilbert

Same as Item 2.

CAUSE OF DEATH

PARTIAL

Multiple gunshot wounds

401X

DATE

2/3/46

PARA 101

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

US ARMY

Burial

6-7-67

Parklawn Cemetery

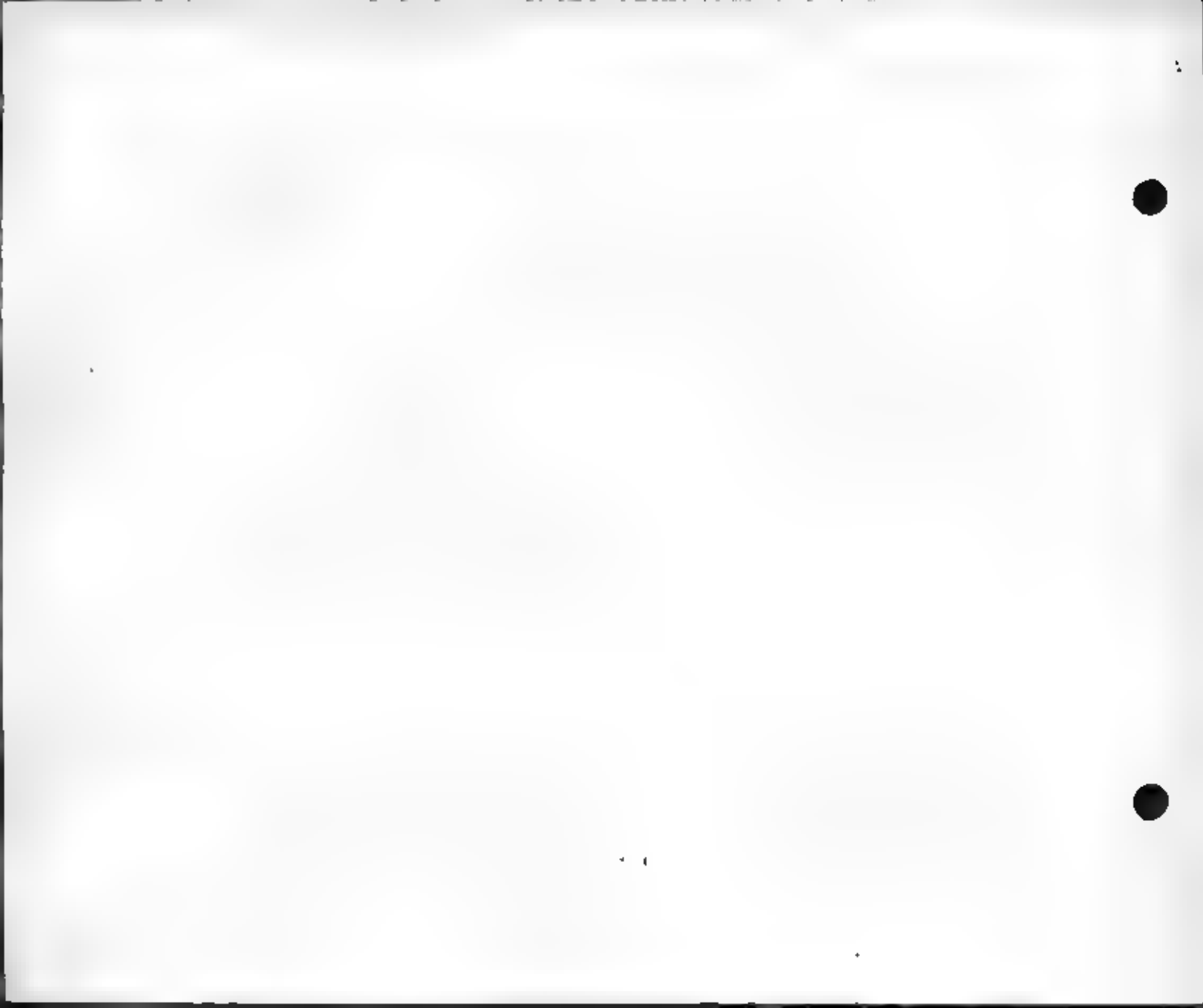
Rockville, Maryland

ROBERT A. PUMPHREY, Bethesda, Maryland

JUN 8

1967

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, direct to page 3 should be data had to use as the burial transit permit. Then please remove to the Registrar's Office. This should be filed with the State Dept of Health prior to burial, cremation or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07763

CERTIFICATE OF DEATH

07747

PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" Mount Wilson		c. STATE MARYLAND		d. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) e. STATE MARYLAND		f. COUNTY P. 18	
g. LENGTH OF STAY IN b 2 1/2 mo.		h. CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" Baltimore		i. STREET ADDRESS Mount Wilson State Hospital		j. IS RESIDENT ON 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 1448. 1449. 1450. 1451. 1452. 1453. 1454. 1455. 1456. 1457. 1458. 1459. 1460. 1461. 1462. 1463. 1464. 1465. 1466. 1467. 1468. 1469. 1470. 1471. 1472. 1473. 1474. 1475. 1476. 1477. 1478. 1479. 1480. 1481. 1482. 1483. 1484. 1485. 1486. 1487. 1488. 1489. 1490. 1491. 1492. 1493. 1494. 1495. 1496. 1497. 1498. 1499. 1500. 1501. 1502. 1503. 1504. 1505. 1506. 1507. 1508. 1509. 1510. 1511. 1512. 1513. 1514. 1515. 1516. 1517. 1518. 1519. 1520. 1521. 1522. 1523. 1524. 1525. 1526. 1527. 1528. 1529. 1530. 1531. 1532. 1533. 1534. 1535. 1536. 1537. 1538. 1539. 1540. 1541. 1542. 1543. 1544. 1545. 1546. 1547. 1548. 1549. 1550. 1551. 1552. 1553. 1554. 1555. 1556. 1557. 1558. 1559. 1560. 1561. 1562. 1563. 1564. 1565. 1566. 1567. 1568. 1569. 1570. 1571. 1572. 1573. 1574. 1575. 1576. 1577. 1578. 1579. 1580. 1581. 1582. 1583. 1584. 1585. 1586. 1587. 1588. 1589. 1590. 1591. 1592. 1593. 1594. 1595. 1596. 1597. 1598. 1599. 1600. 1601. 1602. 1603. 1604. 1605. 1606. 1607. 1608. 1609. 1610. 1611. 1612. 1613. 1614. 1615. 1616. 1617. 1618. 1619. 1620. 1621. 1622. 1623. 1624. 1625. 1626. 1627. 1628. 1629. 1630. 1631. 1632. 1633. 1634. 1635. 1636. 1637. 1638. 1639. 1640. 1641. 1642. 1643. 1644. 1645. 1646. 1647. 1648. 1649. 1650. 1651. 1652. 1653. 1654. 1655. 1656. 1657. 1658. 1659. 1660. 1661. 1662. 1663. 1664. 1665. 1666. 1667. 1668. 1669. 1670. 1671. 1672. 1673. 1674. 1675. 1676. 1677. 1678. 1679. 1680. 1681. 1682. 1683. 1684. 1685. 1686. 1687. 1688. 1689. 1690. 1691. 1692. 1693. 1694. 1695. 1696. 1697. 1698. 1699. 1700. 1701. 1702. 1703. 1704. 1705. 1706. 1707. 1708. 1709. 1710. 1711. 1712. 1713. 1714. 1715. 1716. 1717. 1718. 1719. 1720. 1721. 1722. 1723. 1724. 1725. 1726. 1727. 1728. 1729. 1730. 1731. 1732. 1733. 1734. 1735. 1736. 1737. 1738. 1739. 1740. 1741. 1742. 1743. 1744. 1745. 1746. 1747. 1748. 1749. 1750. 1751. 1752. 1753. 1754. 1755. 1756. 1757. 1758. 1759. 1760. 1761. 1762. 1763. 1764. 1765. 1766. 1767. 1768. 1769. 1770. 1771. 1772. 1773. 1774. 1775. 1776. 1777. 1778. 1779. 1780. 1781. 1782. 1783. 1784. 1785. 1786. 1787. 1788. 1789. 1790. 1791. 1792. 1793. 1794. 1795. 1796. 1797. 1798. 1799. 1800. 1801. 1802. 1803. 1804. 1805. 1806. 1807. 1808. 1809. 1810. 1811. 1812. 1813. 1814. 1815. 1816. 1817. 1818. 1819. 1820. 1821. 1822. 1823. 1824. 1825. 1826. 1827. 1828. 1829. 1830. 1831. 1832. 1833. 1834. 1835. 1836. 1837. 1838. 1839. 1840. 1841. 1842. 1843. 1844. 1845. 1846. 1847. 1848. 1849. 1850. 1851. 1852. 1853. 1854. 1855. 1856. 1857. 1858. 1859. 1860. 1861. 1862. 1863. 1864. 1865. 1866. 1867. 1868. 1869. 1870. 1871. 1872. 1873. 1874. 1875. 1876. 1877. 1878. 1879. 1880. 1881. 1882. 1883. 1884. 1885. 1886. 1887. 1888. 1889. 1890. 1891. 1892. 1893. 1894. 1895. 1896. 1897. 1898. 1899. 1900. 1901. 1902. 1903. 1904. 1905. 1906. 1907. 1908. 1909. 1910. 1911. 1912. 1913. 1914. 1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 214			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health prior to burial. Removal and return of these pages within 72 hours after death is required.

VS A 5
20 M 66

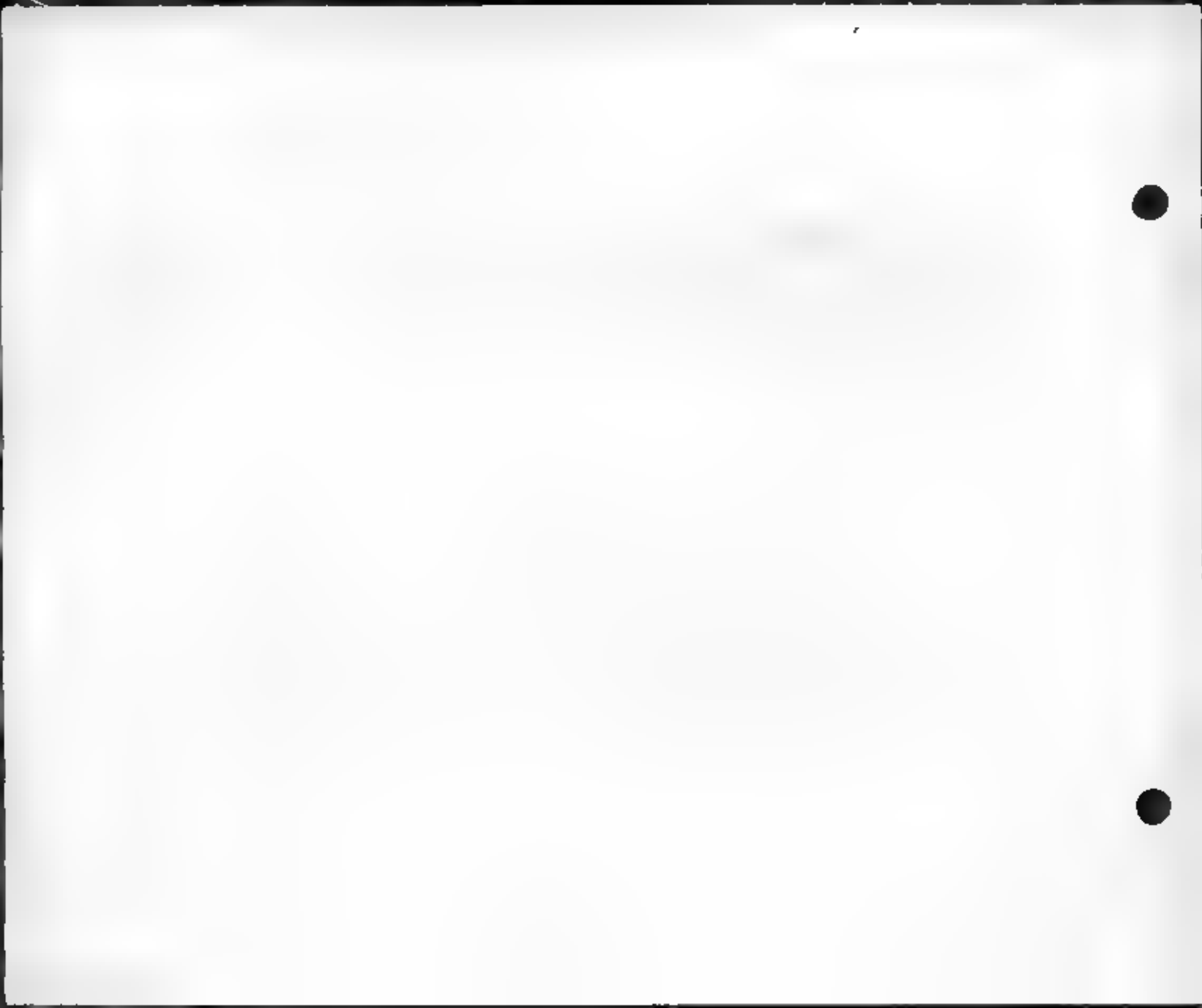
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

77766

CERTIFICATE OF DEATH

07748

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if in United States) Residence before admission a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 8 Church Road	
3. NAME OF DECEASED First Middle Last Catherine A. Gilligan		4. DATE OF DEATH Month Day Year June 18 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1898
9. AGE in years last birthday 69		10. IF UNDER 1 YEAR Months Days Hours Mins 69	
11. OCCUPATION (Give kind of work done during past 10 years, if any, if retired) Laundry work		12. BIRTHPLACE (County & State or foreign country) New York	
13. FATHER'S NAME Andrew Gilligan		14. MOTHER'S MAIDEN NAME Catherine Walsh	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 097-01-0470	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: (a) Myocardial infarction DUE TO Arteriosclerosis (b) Prolonged DUE TO hypertension (c) coronary artery disease Conditions if any which gave rise to immediate cause a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE) (CONDITION GIVEN IN PART I (a)) Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. IN WHAT BETWEEN ONSET AND DEATH	
20a. ACTING CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II or item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, Factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (for this hospital) attended the deceased from Jan. 1 1967 to June 18 1967 that we last saw the deceased alive on June 16 1967 and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE George Redon		22b. DATE SIGNED JUN-18-67	
22c. PHYSICIAN'S NAME (Type) George Redon		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE TIME OF 6-20-1967	23c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery	23d. LOCATION (City or town) (County) (State) Piscataway Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR JUN 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		26. REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary, please use the certificate with the word "pending" in pen or type. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health. If it is desired to bury, cremation or removal, and in any event within 72 hours of death, it is official death.

VR A SHE 131
OM '66

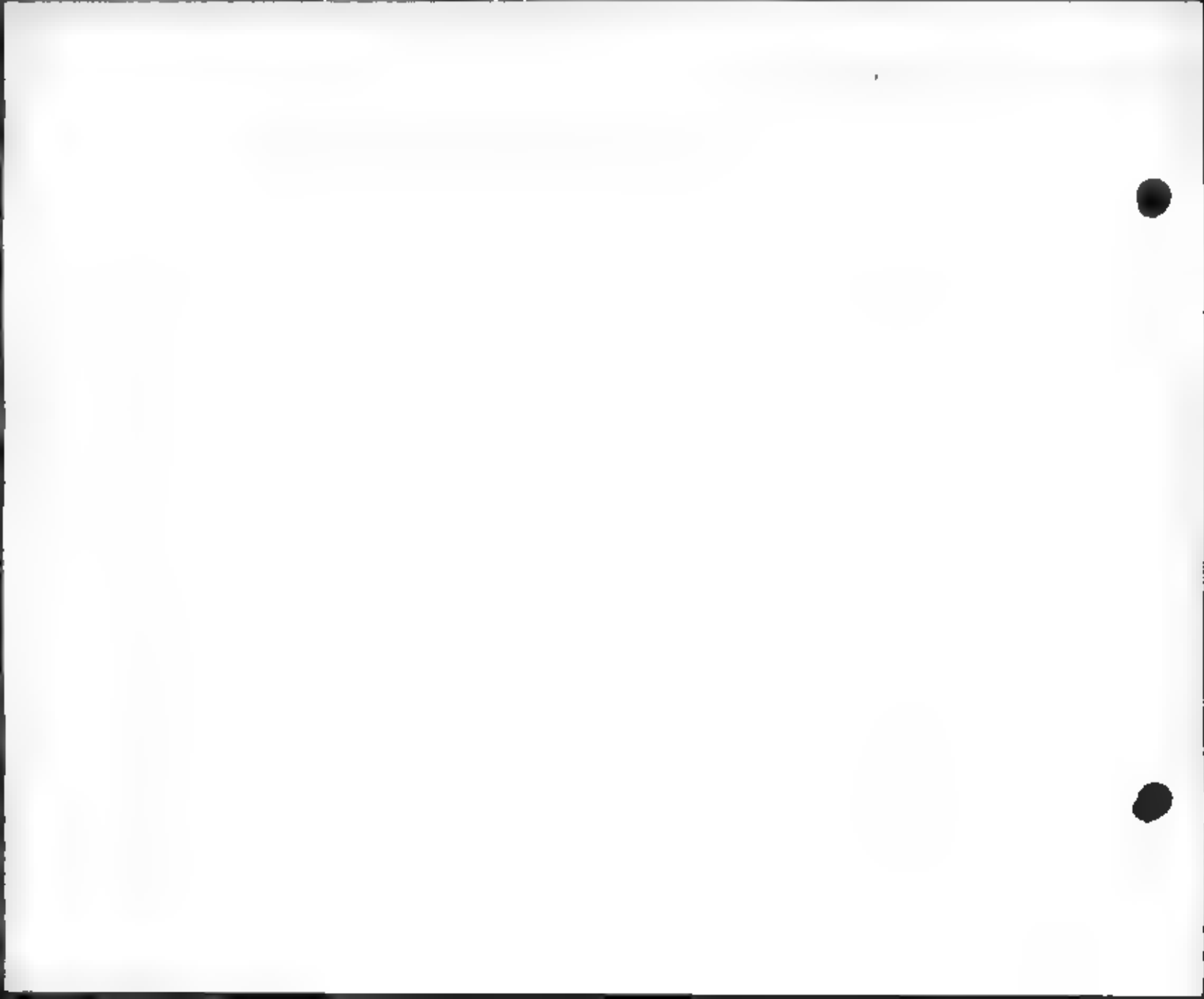
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07710

PLACE OF DEATH CITY Baltimore		USUAL RESIDENCE of the deceased lived in Baltimore before death To Md. Baltimore	
Baltimore		Baltimore	
D.O.A.		D.O.A.	
NAME OF HOSPITAL OR PLACE OF DEATH Balto. Co. Gen. Hosp.		DECEASED'S ADDRESS 3203 Taney Rd.	
NAME OF DECEASED Joseph Glazer		DATE OF DEATH June 18 1967	
SEX Male		AGE 58	
RACE White		BIRTH DATE Aug. 5, 1908	
MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BIRTH PLACE Baltimore, Md.	
CAUSE OF DEATH Auto Repairs		MOTHER'S MAIDEN NAME Anna	
FATHER'S NAME Kasirel		INFORMANT Barbara Glazer, 3203 Taney Rd., Balto., Md.	
No		217-32-8939	
CAUSE OF DEATH PART I: DEATH WAS CAUSED BY Coronary Artery Disease			
PART II: OTHER AGGRAVATING CONDITIONS ON RIGHT HEART NO RELATED TO HEART DISEASE AND NO VENTRICULAR			
PRIMARY CAUSE OF DEATH none			
20a TIME OF DEATH none			
20b INJURY OR DISEASE none			
20c PLACE OF INJURY OR DISEASE none			
20d PLACE OF DEATH none			
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples, M. D.		22 DATE SIGNED 6-19-67	
EXAMINER'S NAME D. D. Caples, M. D.		6 Hanover Rd., Reisterstown, Md.	
23a BIRTH DATE 6/17/1908		23b NAME OF CEMETERY OR CREMATORY B'nai Israel	
23c LOCATION BALTO		23d LOCATION BALTO	
24 FUNERAL DIRECTOR SYLVAN S. LEWIS & Son Inc		25a REC'D BY REGISTRAR JUN 21 1967	
25b REGISTRAR'S SIGNATURE GARRISON		25c REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

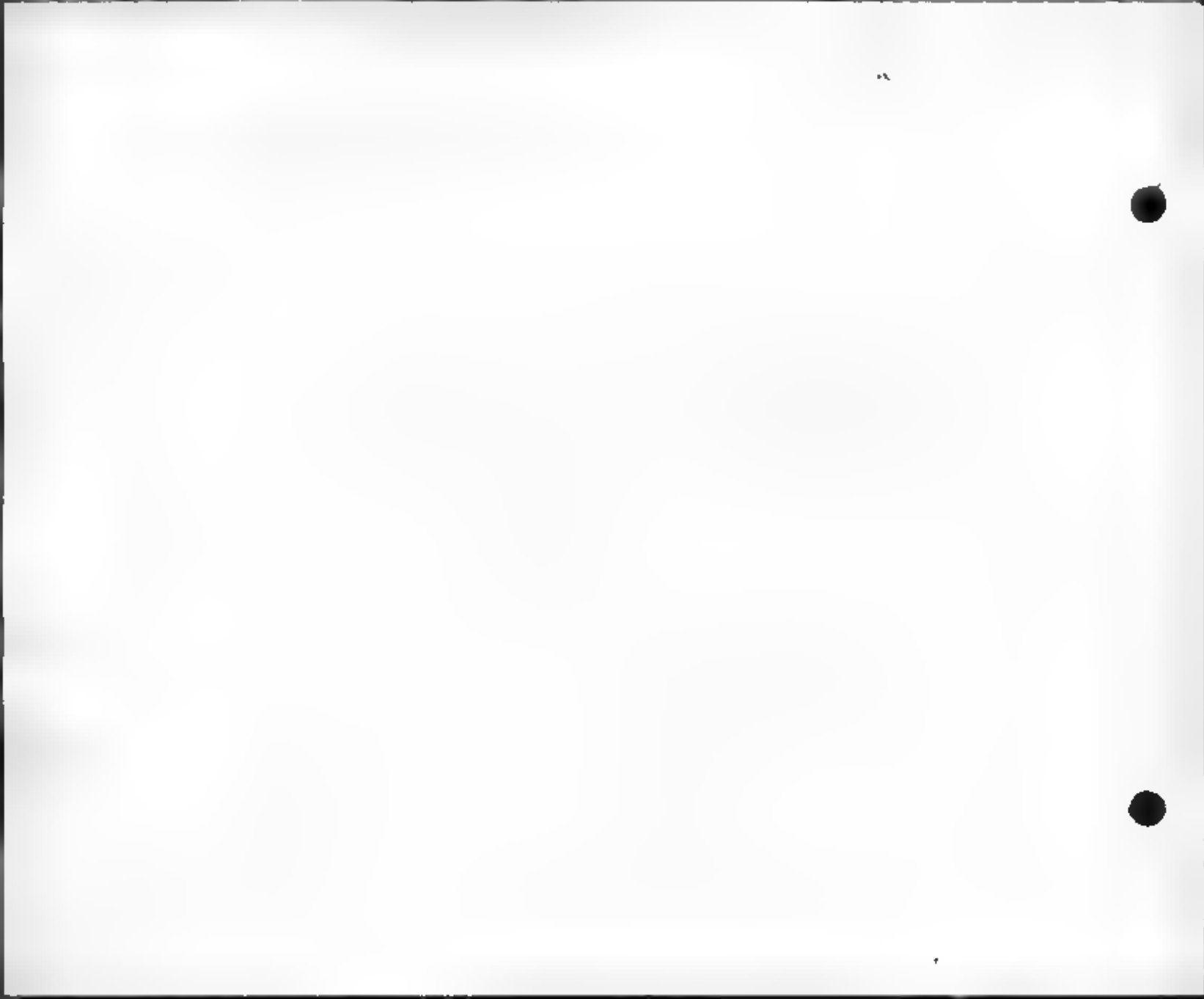
CERTIFICATE OF DEATH

07768

07750

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if in institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN If outside corporate limits write RURAL and give nearest town <u>Towson</u>				c. CITY OR TOWN If outside corporate limits write RURAL and give nearest town <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address <u>St. Joseph's Hospital</u>				d. STREET ADDRESS <u>21 Linden Terrace #21204</u>			
3 NAME OF DECEASED (Type or print) <u>Joseph Bernard Gocke</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>June 10, 1901</u>	
9 AGE <u>66</u> years last birth day		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11 IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		12 IF UNDER 72 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
13 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.H. Eyer Const. Equip. Co. Const. Equip. Grafton, West Virginia</u>				14 BIRTHPLACE (County & State or foreign country) <u> </u>			
15 FATHER'S NAME <u>George Vincent Gocke</u>				16 MOTHER MAIDEN NAME <u>Lucy Agnes Mattingly</u>			
17 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				18 SOCIAL SECURITY NO <u>212-09-2201</u>		19 INFORMANT <u>Mrs. M.F. Gocke</u> address <u>same as 2</u>	
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis, left coronary artery</u> CONDITIONS, if any, which gave rise to immediate cause (b) <u> </u> STATE the underlying cause (c) <u> </u>							
21 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Coronary insufficiency</u>							
22a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				22b. DESCRIBE HOW INJURY OCCURRED (nature of injury in Part I or Part II at item B) <u> </u>			
23a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				23b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
24a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				24b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
25a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				25b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
26a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				26b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
27a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				27b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
28a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				28b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
29a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				29b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
30a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				30b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
31a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				31b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
32a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				32b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
33a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				33b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
34a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				34b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
35a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				35b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
36a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				36b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
37a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				37b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
38a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				38b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
39a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				39b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
40a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				40b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
41a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				41b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
42a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				42b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
43a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				43b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
44a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				44b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
45a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				45b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
46a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				46b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
47a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				47b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
48a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				48b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
49a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				49b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
50a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				50b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
51a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				51b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
52a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				52b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
53a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				53b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
54a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				54b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
55a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				55b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
56a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				56b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
57a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				57b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
58a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				58b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
59a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				59b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
60a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				60b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
61a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				61b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
62a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				62b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
63a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				63b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
64a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				64b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
65a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				65b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
66a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				66b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
67a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				67b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
68a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				68b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
69a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				69b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
70a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				70b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
71a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				71b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
72a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				72b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
73a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				73b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
74a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				74b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
75a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				75b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
76a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				76b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
77a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				77b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
78a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				78b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
79a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				79b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
80a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				80b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
81a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				81b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
82a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				82b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
83a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				83b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
84a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				84b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
85a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				85b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
86a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				86b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
87a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				87b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
88a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				88b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
89a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				89b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
90a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				90b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
91a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				91b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
92a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				92b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
93a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				93b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
94a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				94b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
95a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				95b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
96a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				96b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
97a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				97b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
98a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				98b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
99a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				99b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			
100a. TIME OF INJURY Month <u>June</u> Day <u>22</u> Year <u>1967</u>				100b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to serve as the burial transit permit. Then please remove the non-permanent pages 1 and 2 and should be filed with the State Dept. of Health prior to burial cremation or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The following is the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event within 72 hours after death.

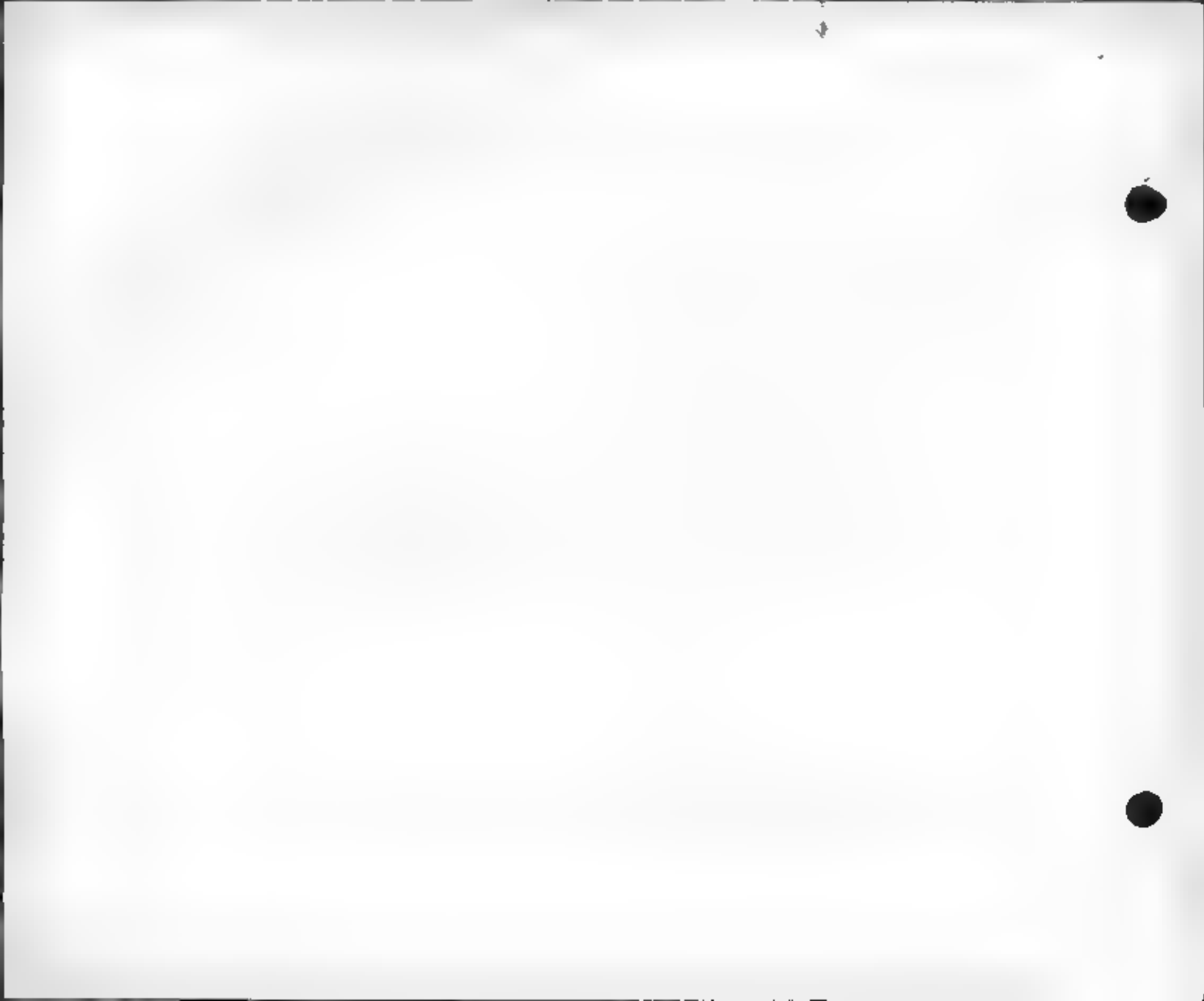
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07769

CERTIFICATE OF DEATH

07751

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE Where deceased resided before admission a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Small		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST JOSEPH'S HOSPITAL		d. STREET ADDRESS Apt 510 Horizon House	
3 NAME OF DECEASED (Type or print) MICHAEL GOLDSTEIN		4 DATE OF DEATH Month June Day 15 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 15, 1893
9 AGE years 71		10 UNDER 21 HRS. Months 0 Days 0 Hours 0 Minutes 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Small Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Bar	
11 BIRTHPLACE (County & state or foreign country) Baltimore, Md.		12 COUNTRY OF BIRTH USA	
13 FATHER'S NAME Louis Goldstein		14 MOTHER'S MAIDEN NAME Winnie ?	
15a. WAS DECEASED EVER IN ARMED SERVICES? (Yes, give date; if unknown, write "yes" or "no") Yes		15b. SOCIAL SECURITY NO. 213 2 5092	
16 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis (b) Ch. cardio vascular disease (c) fast		17 INFORMANT Mrs. Beverly Eastern-4238 Ladene Dr	
18 CONDITIONS (If any, which gave rise to immediate cause, stating the underlying cause last.)		19 INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT FINDINGS: CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		20a. A. IDENTIFY UNDERLYING DISEASE (If either, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY Month June Day 13 Year 1967	
20c. INJURY DESCRIBED 20d. PLACE OF INJURY Home farm factory street office bldg. or 20e. CITY OR TOWN 20f. COUNTY		20g. PLACE OF INJURY Home farm factory street office bldg. or 20h. CITY OR TOWN 20i. COUNTY	
21 I certify that (1) this hospital attended the deceased from saw the deceased alive on 6-7-1967 , and that death occurred at 9:28 on June 13 1967 that (2) death was due to M , from causes and on the date stated above		22a. SIGNATURE Dr. H. Edmund Levin	
22b. PHYSICIAN'S NAME (Type) Dr. H. Edmund Levin		22c. ADDRESS 1790 N. Belvedere Ave.	
23a. SURGEON GENERAL'S OFFICE (Specify)	23b. DATE THEREOF 6/15/67	23c. NAME OF CHURCH OR CEMETERY Beth Tefloah Cong.	23d. LOCATION (City or town, county, state) Baltimore, Md.
24 FUNERAL DIRECTOR GOL LEVINSON & BROS INC. 6010 Reist Rd.	25a. RECEIVED BY REGISTRAR June 21 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALT MORE MARYLAND 21201

CERTIFICATE OF DEATH

077770

07752

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Cecil	
b CITY OR TOWN If outside corporate limits write RURAL and give nearest town Catonville		c CITY OR TOWN If outside corporate limits write RURAL and give nearest town Northeast, Maryland	
d NAME OF HOSPITAL OR INSITUATION If not in hospital give street address Spring Grove State Hospital		d STREET ADDRESS 107 E. Jethro St.	
3 NAME OF DECEASED Type of print LORETTA E. GOODNOW Middle Last		4 DATE OF DEATH Month Day Year June 11, 1967	
5 SEX female	6 COLOR OR RACE white	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-8-08
9 AGE In years b Day b Month b Year 59		10 IF UNDER 1 YEAR IF UNDER 24 HRS Month Day Hours Min 59	
11a USUAL OCCUPATION Give kind of work done during last 30 working days, even if retired Housewife		11b KIND OF BUSINESS OR HOME Home	
12 BIRTHPLACE county & State or foreign country Chester Co. Pa.		13 CITIZENSHIP U.S.	
14 FATHER'S NAME Gardner Todd		15 MOTHER'S MAIDEN NAME Mary Batters	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service NO		17 SOCIAL SECURITY NO 213-20-8954	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a CONGESTIVE HEART FAILURE b c DUE TO DUE TO		19 REAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO HE CRIMINAL DISEASE AND TION GIVEN IN PART I		20 WAS A DEATH PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a A. TO WHOM WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
22a TIME OF INJURY Month Day Year Hour m pm 19		22b INJURY OCCURRED At work <input type="checkbox"/> Not at work <input type="checkbox"/>	
23a PLACE OF INJURY Home farm factory street office building etc.		23b CITY OR TOWN county State	
24 I certify that this hospital attended the deceased from 5-14 to 6-11 1967 and that death occurred on 6-11 1967 from causes and on the date stated above		25 SIGNATURE Stella Wachslers M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> ASSISTANT PHYSICIAN <input type="checkbox"/> 6-12-67	
26 PHYSICIAN'S NAME Type Stella Wachslers, M.D.		27 ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
28a BURIAL OR CREMATION KLIMOV (Specify) Burial	28b DATE 6/14/67	28c NAME OF CHURCH OR CEMETERY North East Methodist	28d LOCATION city or town county State North East Cecil Md.
29 FUNERAL DIRECTOR Grant Funeral Home		30 REL'D BY R. REGISTRAR JLN 14 1967	
31 SIGNATURE Stella Wachslers		32 SIGNATURE Johnas Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a cremation, or removal, or any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If necessary please execute the certificate within the word pending in person in item 6. Copy pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR Page 3 should be used as a burial form. Permit file page, item 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

077771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

077753

PLACE OF DEATH BALTIMORE		USUAL RESIDENCE BALTIMORE	
NAME OF DECEASED TOWSON		DATE OF DEATH JUNE 23 1967	
NAME OF HOSPITAL ST. JOSEPH HOSPITAL		DATE OF DEATH JUNE 23 1967	
NAME OF DECEASED HERBERT A. GRACEY		DATE OF DEATH JUNE 23 1967	
MARRIAGE MARRIED		DATE OF BIRTH 12-25-06	
INDUSTRY BATTERY GAS KEELER CO		COUNTRY OF BIRTH U.S.A.	
NAME OF DECEASED GEORGE GRACEY		NAME OF DECEASED BERTHA FORNOFF	
CAUSE OF DEATH MYOCARDIAL INFARCTION		DATE OF DEATH JUNE 23 1967	
PART II OTHER SIGNIFICANT CONDITION		DATE OF DEATH JUNE 23 1967	
2. I certify that the death resulted from		Natural cause	
ACTUAL SIGNATURE WILLIAM A. PILLSBURY		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME Type WILLIAM A. PILLSBURY		DEPUTY MEDICAL EXAMINER JAMES H. JONES, MD.	
23. DATE OF BURIAL 6/26/1967		24. NAME OF BURIAL PLACE Moreland Memorial Pk.	
25. NAME OF BURIAL PLACE H.W. Jenkins & Sons Co.		26. ADDRESS OF BURIAL PLACE 4905 York Rd. Baltimore 12, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be released by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and on any other, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND

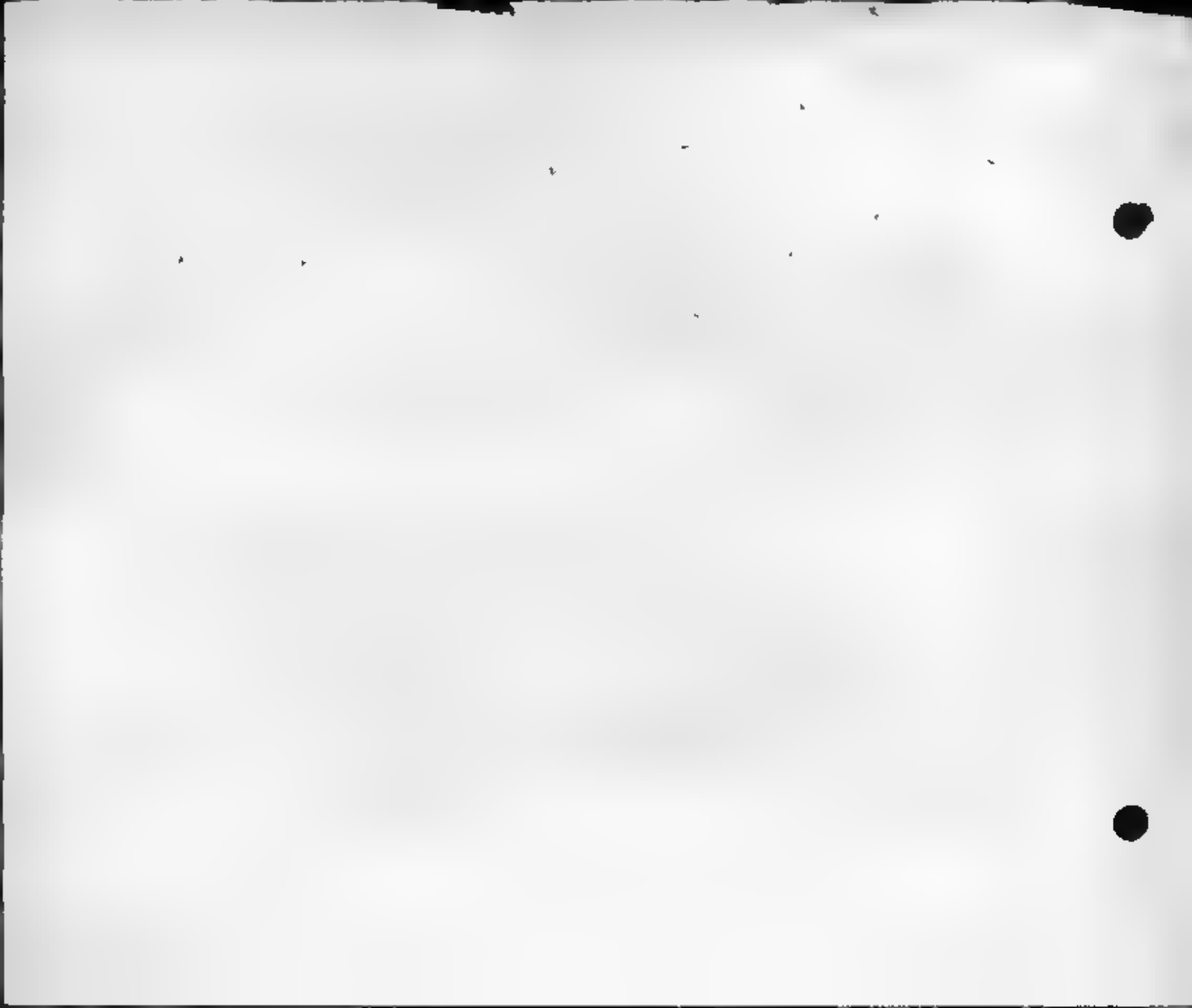
97772

CERTIFICATE OF DEATH

67751

1. PLACE OF DEATH
a. COUNTY Baltimore Co
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Middle River #20
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ivy Hall Nursing Home
d. NAME OF DECEASED (Type or print) Elizabeth Green
e. SEX Female
f. COLOR OR RACE White
g. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
h. USUAL OCCUPATION, if you kind of work done during most of working life, even if mixed AT HOME
i. KIND OF BUSINESS OR INDUSTRY AT HOME
j. FATHER'S NAME FREDERICK KRESSIG
k. MOTHER'S MAIDEN NAME FREDERICKA SICKEL
l. WAS DECLARED EVER IN U.S. ARMED FORCES? ☐ 16. SOCIAL SECURITY NO. 6016 1884
m. INFORMANT MRS ALMA G DENNY 7418 POPULAR AVE
n. RESIDENCE ON A FARM? ☐ YES ☒ NO

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MARYLAND
b. COUNTY CECOTATE
c. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town 7418 POPULAR AVE
d. STREET ADDRESS 7418 POPULAR AVE
e. DATE OF DEATH June 11 1967
f. AGE (In years last birthday) 88 vs. 87
g. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
h. CITIZEN OF WHAT COUNTRY USA
i. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE PULMONARY EDEMA
DUE TO ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE
CONDITIONS, is any which gave rise to immediate cause or showing the underlying cause last
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE DISEASE CONDITION GIVEN IN PART I PARKINSON'S DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. TIME OF INJURY Month Day Year 20b. INJURY OCCURRED 20c. PLACE OF INJURY Home farm factory street office bldg etc
20d. CITY OR TOWN 20e. STATE
21. I certify that (this hospital) attended the deceased from NOV 23 1961 to JUNE 11 1967 that (I) (we) last saw the deceased alive on MAR. 29 1967 and that death occurred at 12:00 PM from the causes and on the date stated above.
22a. SIGNATURE Joseph Miceli 22b. ADDRESS 108 S TAYLOR AVE
22c. PHYSICIAN'S NAME TYPE JOSEPH MICELI MD 22d. ADDRESS 108 S TAYLOR AVE
23a. BURIAL CREMATION 23b. DATE THEREOF 6/14/67 23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN 23d. LOCATION City town or county State CECOTATE MD
24. FUNERAL DIRECTOR'S SIGNATURE WILLIAM FURBER HOME DUNDALK MD 25a. DATE JUN 19 1967 25b. SIGNATURE James J. J...

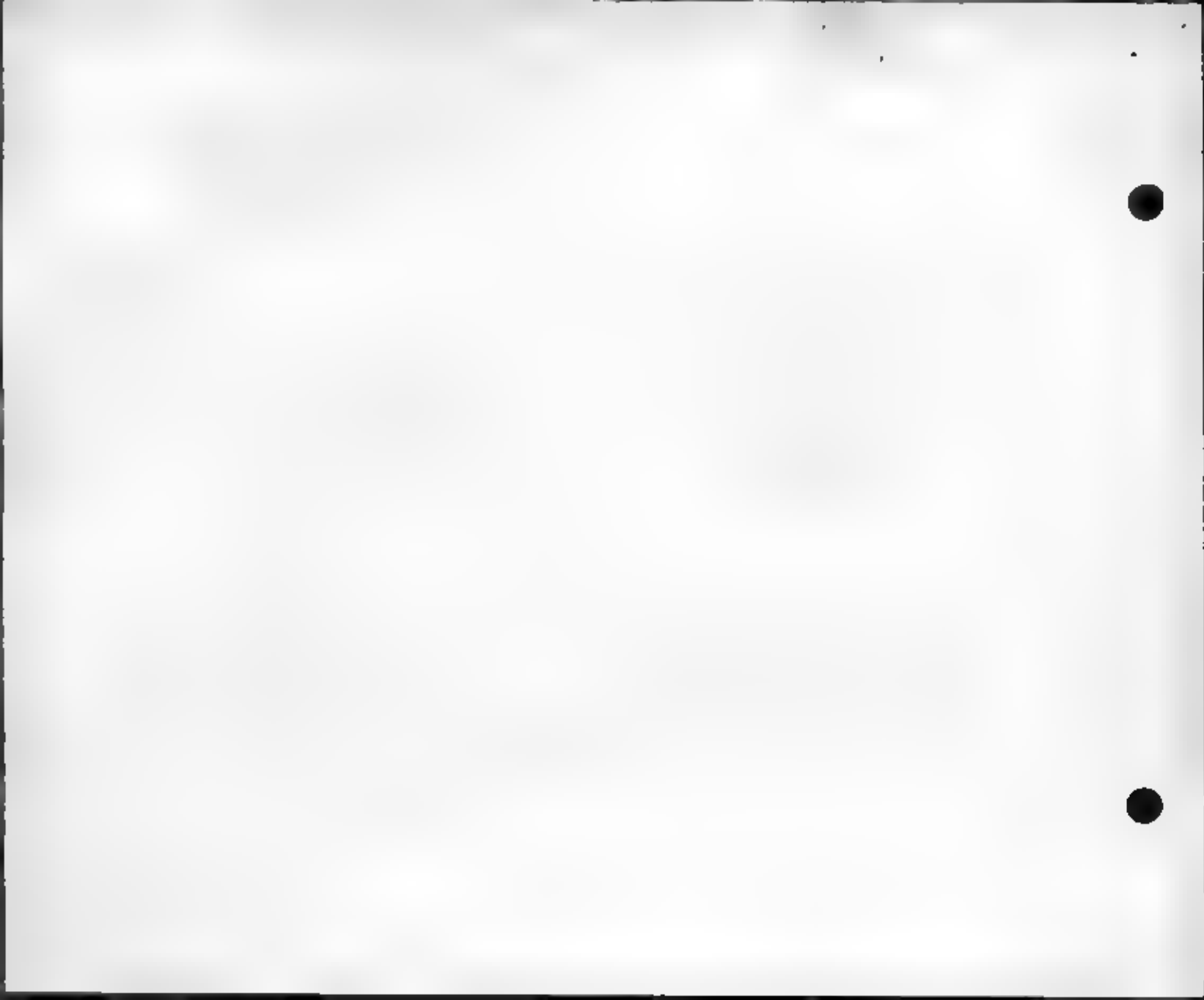


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

33-27

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>4 yrs 2 mos</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR NEST TLT DN (If not in hospital, give street address) <u>Professional House</u>				d. STREET ADDRESS <u>Apartment</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>H.</u> Last <u>Greenbaum</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/27/31</u>		9. AGE in years last birthday <u>5</u> yrs.		F UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Michael Holzman</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Kauer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>				16. SOCIAL SECURITY NUMBER <u>NO</u>				17. INFORMANT <u>Arthur Karpfheimer - 6307 Wallace Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO (b). DUE TO (c). <u>Myocardial infarction</u> <u>Hypertension</u> <u>Arteriosclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>9</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>March 1955</u> to <u>June 5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>67</u> and that death occurred at <u>7:30</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William Bernstein</u>				22b. ADDRESS <u>819 Park Avenue</u>				22c. DATE SIGNED <u>June 5/67</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. H. B. Berkman</u>				22e. ADDRESS <u>819 Park Avenue</u>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 6/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>											
24. FUNERAL DIRECTOR <u>Vol. Korman & Son - 6000 Reisterstown Road</u>				25a. REC'D BY REGISTRAR <u>ILN 8</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

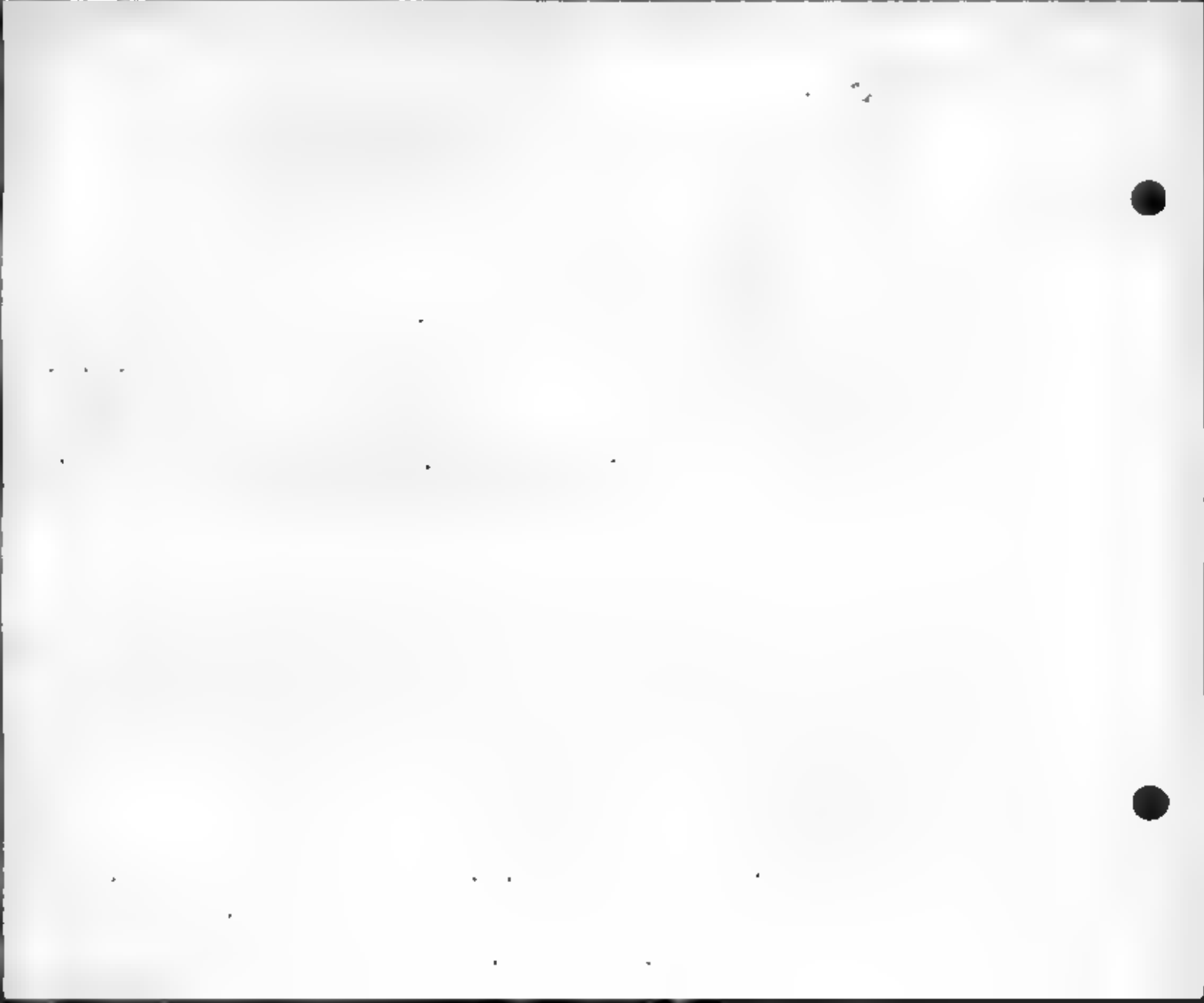


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER

TO FUNERAL DIRECTOR

37774				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				27753			
PLACE OF DEATH COUNTY Baltimore				JUDICIAL RESIDENCE STATE Maryland				COUNTY Baltimore			
write RURAL and give nearest town Dundalk				write RURAL and give nearest town Dundalk				write RURAL and give nearest town Dundalk			
AGE 10 yrs.				DATE OF DEATH June 2 67				DATE OF DEATH June 2 67			
NAME OF DECEASED Edith Evelyn Groves				NAME OF DECEASED Edith Evelyn Groves				NAME OF DECEASED Edith Evelyn Groves			
SEX Female				SEX Female				SEX Female			
RACE White				RACE White				RACE White			
MARRIED <input checked="" type="checkbox"/> Yes				MARRIED <input checked="" type="checkbox"/> Yes				MARRIED <input checked="" type="checkbox"/> Yes			
OCCUPATION Housewife				OCCUPATION Housewife				OCCUPATION Housewife			
FATHER'S NAME John L. Goodrich				MOTHER'S NAME Pearl Olive Hostuttler				MOTHER'S NAME Pearl Olive Hostuttler			
INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.				INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.				INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.			
CAUSE OF DEATH Cornary Occlusion				CAUSE OF DEATH Cornary Occlusion				CAUSE OF DEATH Cornary Occlusion			
CONDITIONS, if any, which gave rise to death 4 days				CONDITIONS, if any, which gave rise to death 4 days				CONDITIONS, if any, which gave rise to death 4 days			
FATHER'S NAME John L. Goodrich				MOTHER'S NAME Pearl Olive Hostuttler				MOTHER'S NAME Pearl Olive Hostuttler			
INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.				INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.				INFORMANT (Husband) Harvey J. Groves, 3114 Sollers Point Rd.			
ACTUAL SIGNATURE Melvin B. Davis				ACTUAL SIGNATURE Melvin B. Davis				ACTUAL SIGNATURE Melvin B. Davis			
NAME Melvin B. Davis				NAME Melvin B. Davis				NAME Melvin B. Davis			
DATE June 5-1967				DATE June 5-1967				DATE June 5-1967			
PLACE OF BURIAL Burial				PLACE OF BURIAL Burial				PLACE OF BURIAL Burial			
NAME John J. Duda, 7922 Wise Ave. Dundalk, Md.				NAME John J. Duda, 7922 Wise Ave. Dundalk, Md.				NAME John J. Duda, 7922 Wise Ave. Dundalk, Md.			
DATE June 5-1967				DATE June 5-1967				DATE June 5-1967			
SIGNATURE Charles Judge				SIGNATURE Charles Judge				SIGNATURE Charles Judge			



1
77725
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

77757

1 PLACE OF DEATH a. <u>Baltimore</u> b. CITY OR TOWN <u>Rancho Hills</u> c. <u>outside corporate limits</u> d. NAME OF HOSPITAL OR INSTITUTION <u>Baltimore County General</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>7</u> c. CITY OR TOWN <u>Baltimore</u> d. STREET ADDRESS <u>3609 Sussex Rd</u>	
3 NAME OF DECEASED First <u>Charles</u> Middle <u>Alvin</u> Last <u>Gugliuzza</u>		4 DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 CO-OR OR RACE <u>wh.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>2/25/93</u>
9 AGE in years <u>74</u>		10 ASSESSMENT OF DEATH IF UNDER 1 YEAR: Month <u>7</u> Day <u>4</u> Hours <u>14</u> Min <u>10</u>	
11a. KIND OF BUSINESS OR OCCUPATION <u>Barber</u>		11b. KIND OF BUSINESS OR OCCUPATION <u>Self Employed</u>	
12 BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		13 CITIZEN OF WHAT COUNTRY? <u>...</u>	
14 FATHER'S NAME <u>Saverio Gugliuzza</u>		15 MOTHER'S MAIDEN NAME <u>Carmella Fedele</u>	
16a. WAS DECEASED EVER IN ARMED SERVICES? <u>NO</u>		16b. ADJUTANT GENERAL'S NO. <u>212-164360</u>	
17a. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: IMMEDIATE CAUSE a. <u>...</u> b. <u>...</u> c. <u>...</u>		17b. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>...</u>	
18a. TIME OF INJURY Month <u>...</u> Day <u>...</u> Year <u>...</u>		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19a. PLACE OF INJURY Home farm factory, street, office bldg. etc.] <u>...</u>		19b. (City or town) <u>...</u> (County) <u>...</u> (State) <u>...</u>	
20 I certify that (i) this hospital attended the deceased from <u>...</u> 19 <u>...</u> to <u>...</u> 19 <u>...</u> and that death occurred at <u>...</u> M. from causes and on the date stated above.			
21a. SIGNATURE <u>Milton Schlenger</u>		21b. DATE SIGNED <u>6/5/67</u>	
22a. PHYSICIAN'S NAME (Type) <u>Milton Schlenger</u>		22b. ADDRESS <u>...</u>	
23a. BURIAL CREMATION REMOVAL Specify <u>Burial</u>	23b. DATE THEREOF <u>6/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>...</u> (State) <u>...</u>
24a. REGISTRATION BY REGISTRAR <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a physician's signature. The law requires that the death certificate be executed with a physician's signature. The law requires that the death certificate be executed with a physician's signature.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health or a local health officer within 72 hours after death.

VR A 5 4
25M 67

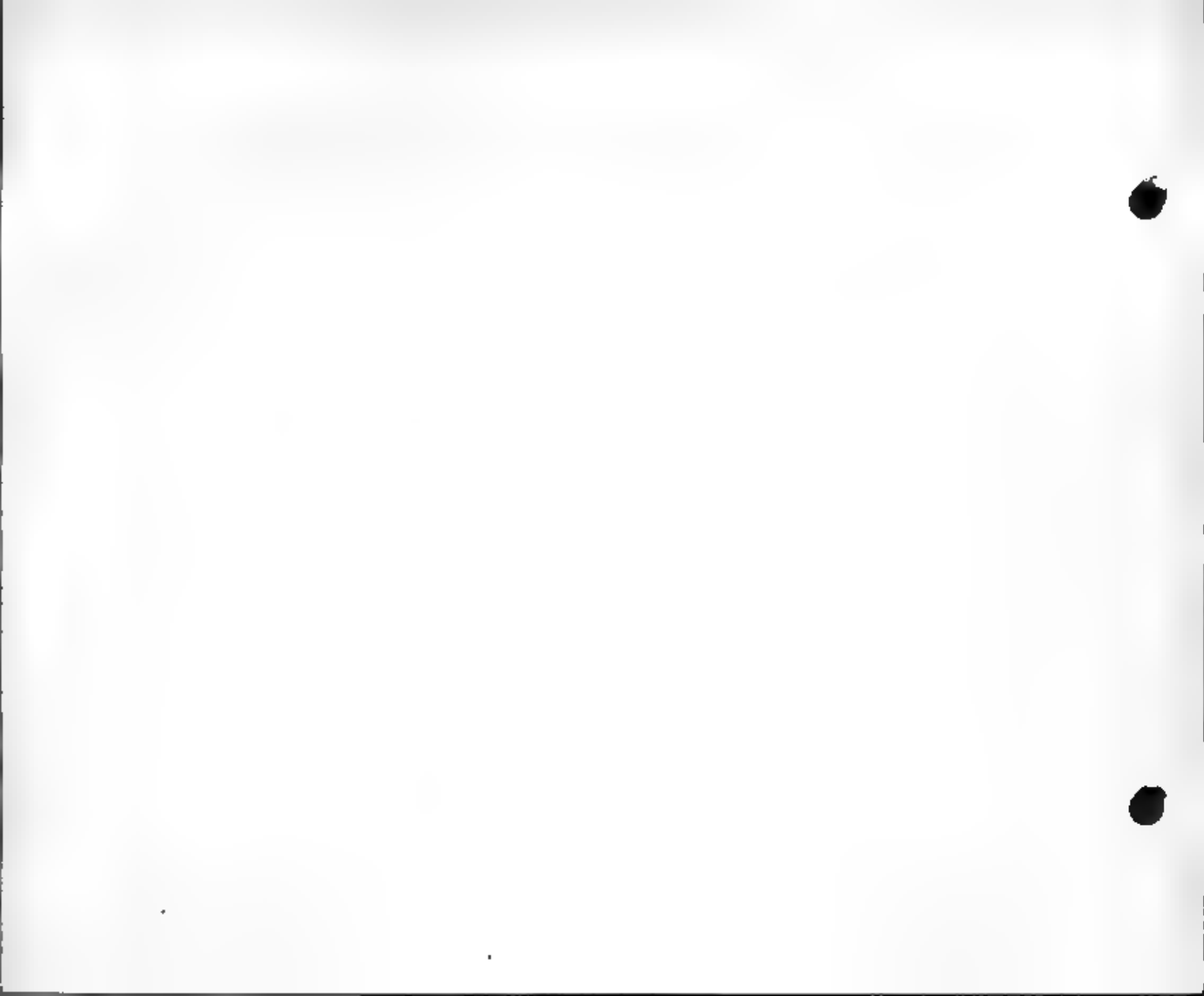
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

077776

CERTIFICATE OF DEATH

077753

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived a portion of time before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
St. Joseph Hospital		10 E Oak Grove Dve.	
3 NAME OF DECEASED (Type in print) Baby Girl		4 DATE OF DEATH Month June Day 11 Year 67	
5 SEX Female b. COLOR OR RACE White c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> d. DATE OF BIRTH 6-10-67		9 AGE in years last birthday 1 35	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 FATHER'S NAME David H. Hagan		12 MOTHER'S MAIDEN NAME Joan Marie Jakum	
13 WANTED, LIVED EVER IN ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		6. SOCIAL SECURITY NO	
7 INFORMANT David Hagan		Address Same	
B CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anencephalus DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (Even in Part I) 20a. I certify that (1) (this hospital attended the deceased from June 10, 1967 to June 11, 1967) and that death occurred at 12:30 AM on the date stated above 20b. I certify that (2) (the deceased died on June 11, 1967) and that death occurred at 12:30 AM on the date stated above		9. WILL AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month June Day 10 Year 67 Hour 9 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm factory street, office bldg. etc.		20f. CITY or town Baltimore County Md. State Md.	
21. SIGNATURE Arturo A. Pidloian M.D.		22. PHYSICIAN'S NAME (Type) Arturo Pidloian, M.D.	
23a. ADDRESS 7620 York Road, Baltimore, Md. 21204		23b. ADDRESS 7620 York Road, Baltimore, Md. 21204	
24. BURIAL INFORMATION a. RITE Burial b. DATE THEREOF June 12, 1967 c. NAME OF CEMETERY OR REPOSITORY Gardens of Faith Cemetery d. ADDRESS Baltimore, Md.		25. OCCASION (Type in own handwriting) June 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

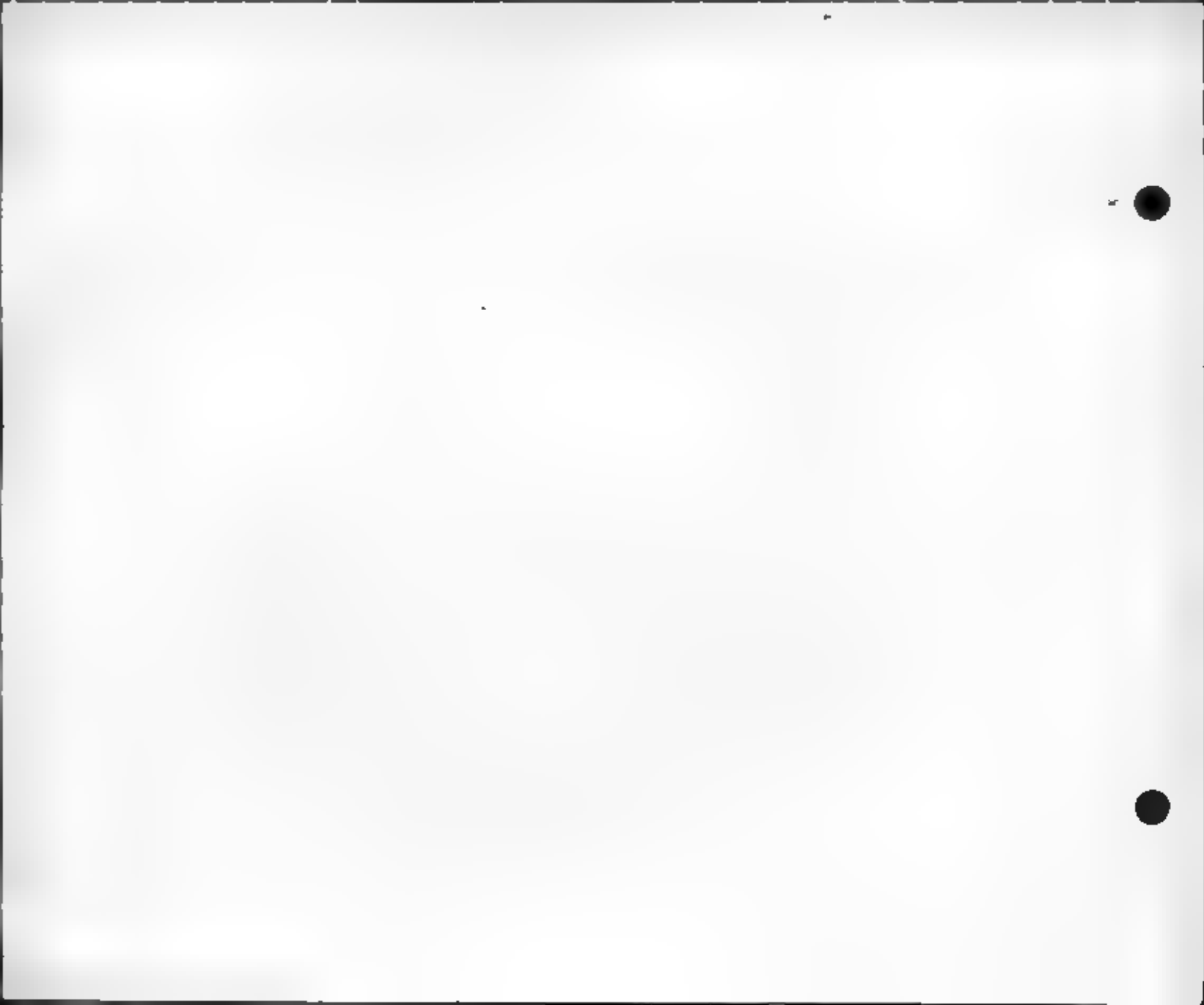
07777

CERTIFICATE OF DEATH

07:50

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN <u>ESSEX</u> c. STATE <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived if inscribed on Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>ESSEX</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>913 RIVERVIEW</u>		4 DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1967</u>	
5 NAME OF DECEASED First <u>JOSEPH</u> Middle <u>C.</u> Last <u>HELMERMAN</u> Sex <u>M</u>		6 DATE OF BIRTH <u>6/1/08</u>	
7 COLOR OR RACE <u>W</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 AGE in years (last birthday) <u>59</u>		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Minutes <u>0</u>	
11a. IS A. D. I. (PAIN) Give kind of work done during most of working life, even if retired		11b. KIND OF BUSINESS OR INDUSTRY <u>MARTINS</u>	
12 BIRTHPLACE (County & State or foreign country) <u>OHIO</u>		13 COUNTRY OF BIRTH <u>U.S.A.</u>	
14 FATHER'S NAME <u>JOSEPH C. HELMERMAN</u>		15 MOTHER'S MAIDEN NAME <u>JOSEPHINE</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO. <u>000-00-0000</u>	
18 INFORMANT <u>JOSEPH HELMERMAN</u>		Address <u>ABOVE</u>	
B. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DL TO <u>100%</u> (b) <u>prob. a lupus probabation</u> DL TO <u>100%</u> (c) <u>100%</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) 19a. WAS A. D. I. (PAIN) UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B. 20b. TIME OF INJURY Month Day Year Hour <u>10</u> AM <u>10</u> PM 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State) 21 I certify that (this hospital) attended the deceased from <u>9</u> to <u>9</u> and that death occurred at <u>10</u> AM, from causes and on the date stated above 22a. SIGNATURE <u>JOSEPH HELMERMAN</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH HELMERMAN</u> 22d. ADDRESS <u>ESSEX, M.D.</u>			
23a. BURIAL, REMOTION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/1/67</u>	
23c. NAME OF CEMETERY OR BURIALITY <u>ST. MARY'S</u>		23d. LOCATION (City or town) (County) (State) <u>ESSEX, M.D.</u>	
24 FUNERAL DIRECTOR <u>JOSEPH HELMERMAN</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>JOSEPH HELMERMAN</u>		25c. REGISTRAR'S NAME <u>JOSEPH HELMERMAN</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial "ans", permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and notify funeral home within 72 hours after death.

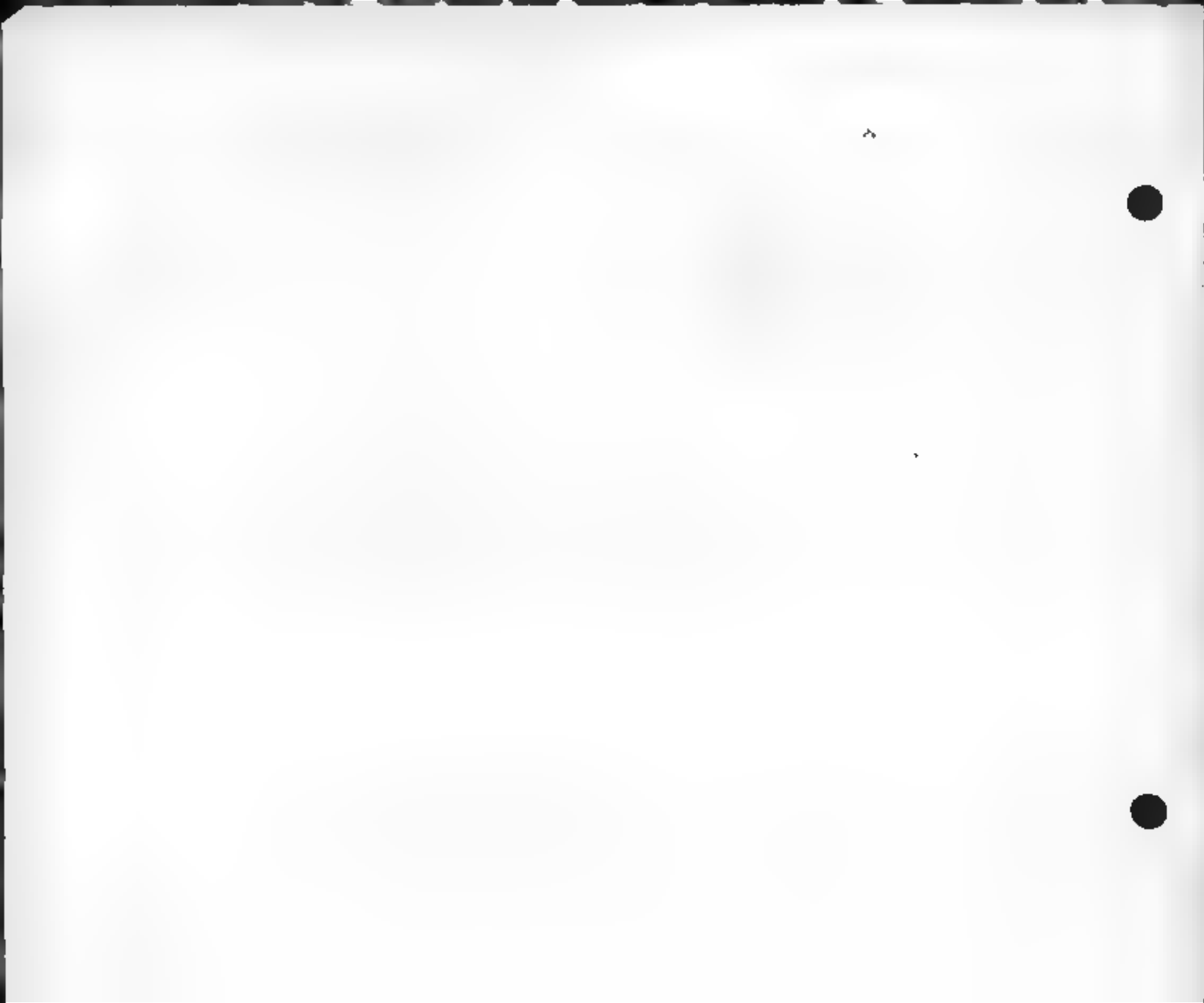


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
77778
CERTIFICATE OF DEATH
07750

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN MD 12 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Josephs Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21221 d. STREET ADDRESS 714 Dorsey Ave.	
3. NAME OF DECEASED (Type or print) Mary A. HALVEY		4. DATE OF DEATH Month June Day 8 Year 19 67	
5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 20, 1921 9. AGE (in years last birthday) 46 yrs. FINDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) OPERATOR SEA AND		10b. KIND OF BUSINESS OR INDUSTRY Galway, Ireland	
11. BIRTHPLACE (County & State, or foreign country) Galway, Ireland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JOHN Mc MURROUGH		14. MOTHER'S MARDEN NAME ABOY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service. NO		16. SOCIAL SECURITY NO. 109-50 534 ANDREW HALVEY	
17. INFORMANT ABOY		Address	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage X DUE TO (b) Ruptured aneurysm of the middle cerebral artery Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (a) DUE TO (c) PART OTHERS GOING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONING PART (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. MYOCARDIAL INFARCTION, acute 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part or Part I of Item 18.) OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m. 3:45 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 , to June 8 , 19 67 , that (I) (we) last saw the deceased alive on June 8 , 19 67 , and that death occurred at 3:45 M. from the causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn		22b. DATE SIGNED 6-8-67	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd. Balto. 21204	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9, 67	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City, town or county) (State) BALTO. MD	
24. FUNERAL DIRECTOR W. S. COCKBURN		25a. REC'D BY REG. STRAR 310 MACE	
25b. REC. STRAR'S SIGNATURE W. S. COCKBURN		DATE JUN 12 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

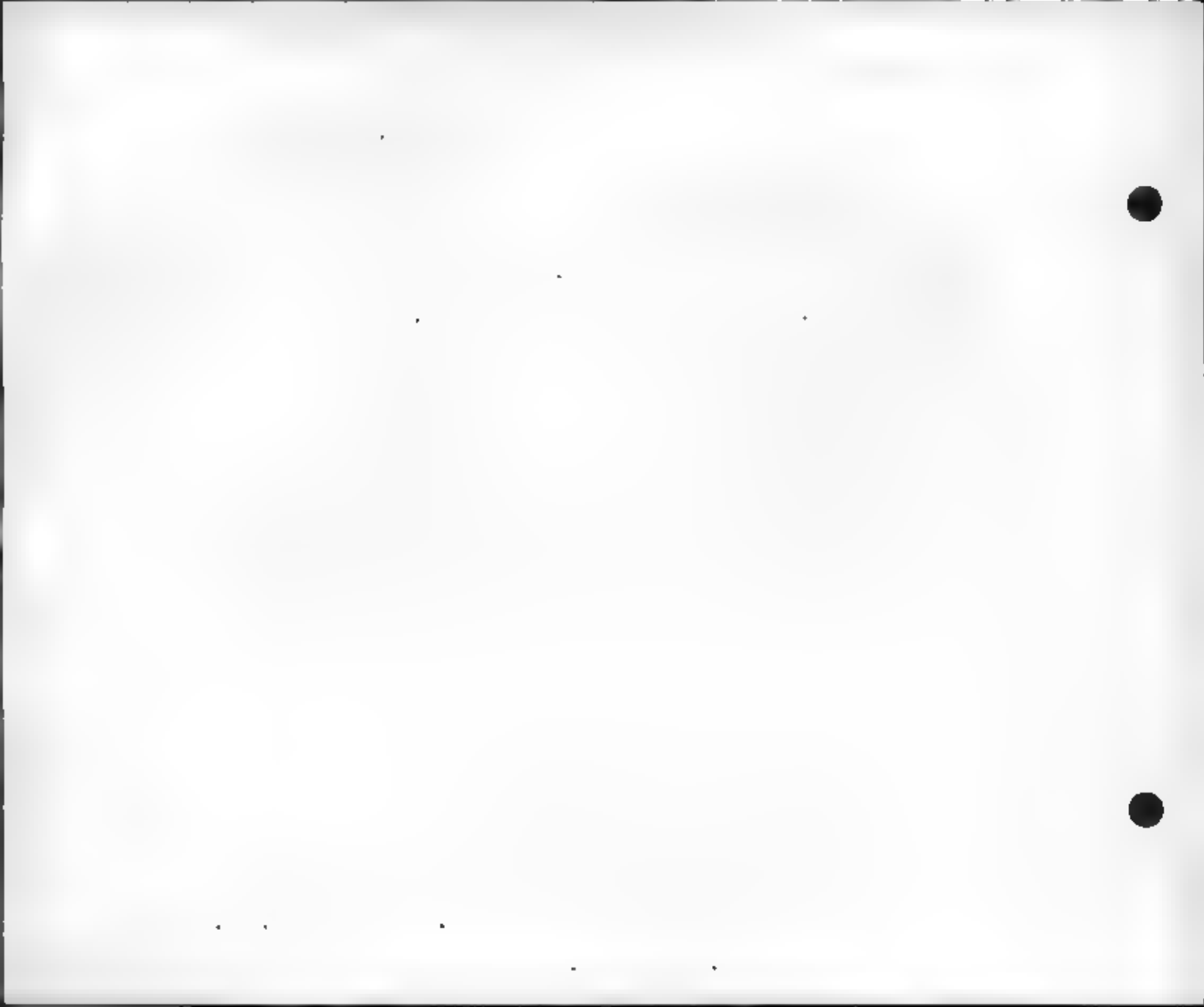
CERTIFICATE OF DEATH

07779

07761

PLACE OF DEATH a COUNTY Baltimore MARYLAND		USUAL RESIDENCE Where deceased lived if institution Residence before admission a STATE Ma. b COUNTY 4	
b CITY OR TOWN "If outside separate limits write RURAL and give nearest town" Towson		c CITY OR TOWN "If outside separate limits write RURAL and give nearest town" Baltimore	
d NAME OF HOSPITAL OR INSTITUTION "If not in hospital, give street address" Chesapeake Manor Nursing Home		e STREET ADDRESS 1801 Sherwood Ave.	
3 NAME OF DECEASED Type at print. First Middle Last Anna M. Hammen		4 DATE OF DEATH Month Day Year 6/ 17/ 1967	
5 SEX F.	6 COLOR OR RACE W.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH May 18, 1882
9 AGE "In year last birthday" yrs 85		10 UNDER YEAR MONTHS DAYS 85	
11 OCCUPATION (Give kind of work done during last week or month, even if retired) Housewife		12 KIND OF BUSINESS OR INDUSTRY Germany	
13 FATHER'S NAME Joseph Pensker		14 MOTHER'S MAIDEN NAME Pauline Becker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. no	
17 INFORMANT Miss Mary Hammen		Address same	
18 CAUSE OF DEATH (Enter only one cause per line for a., (b), and c.) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions if any which gave rise to immediate cause a., stating the underlying cause b: Cerebral thrombosis Small arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT DO NOT RELATE TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I: a			
20a AGE WHEN WAS UNDERLYING DISEASE OR CONTRIBUTING CAUSE OF DEATH FIRST NOTICED BY MEDICAL EXAMINER 19		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a or Part II of item B) While at work	
20c TIME OF INJURY (Month, Day, Year) 19		20d PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory	
21 I certify that (this hospital) attended the deceased from saw the deceased alive on 6/15/67 and the death occurred at 6/17/67 from causes and on the date stated above		22a SIGNATURE OF PHYSICIAN Theodore J. Gragiano	
22b ADDRESS 1634 E. Belvidere 21212		23a DA SIGNED 6/19/67	
23a BURIAL (CREMATION, REMOVAL, etc.) Burial		23b DATE THEREOF 6/20/67	
23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d LOCATION (City or Town) (County) (State) Balto. Md.	
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a RECD BY R. M. RAR JUN 19 1967	
25b REC. BY R. M. RAR Charles Judge		26 SIGNATURE OF JUDGE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and file them in the State Department of Health. Page 4 should be filed with the State Department of Health.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07780

CERTIFICATE OF DEATH

07762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be retained by the funeral director. Page 4 may be retained by the funeral director. Page 4 may be retained by the funeral director.

TO THE STATE DEPARTMENT OF HEALTH: This certificate should be filed with the State Department of Health prior to burial, cremation or removal, and no event within 72 hours after death should be filed with the State Department of Health.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. RURAL OR TOWN Baltimore d. NAME OF HOSPITAL OR INSTITUTION Greater Baltimore Medical Center		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN Lockysville, 21030 d. STREET ADDRESS None e. RESIDENCE ON 4-ARMY None	
3. NAME OF DECEASED First William Middle Joseph Last Harding		4. DATE OF DEATH Month 6 Day 23 Year 1967	
5. SEX Male COLOR OR RACE White		6. DATE OF BIRTH 9-8-97	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE 69 years	
9. OCCUPATION (Give kind of work done during last 12 months or last 12 months) CABINET MAKER-Act.		10. BIRTH PLACE (County & State or foreign country) Texas, Md.	
11. FATHER'S NAME Ephraim Marion Harding		12. MOTHER'S MAIDEN NAME Hannah Hitchcock	
13. MA. DECEASED EVER IN ARMED OR NAVAL SERVICE (If yes give year or dates of service) None		14. ADDRESS OF INFORMANT 218 24 41st Family Records	
15. CAUSE OF DEATH (Enter only the cause per se for a, b, and c) PART I DEATH WAS CAUSED BY a. IMMEDIATE CAUSE (a) 260X b. MYOCARDIAL INFARCTION c. ARTERIOSCLEROTIC CARDIO-VAS DIS d. DIABETES MELLITUS		16. INTERVA. BETWEEN PART I AND PART II	
PART II OTHER SIGNIFICANT CONDITION: CONTRIBUTING TO DEATH BUT NOT RELATED TO HIS TERMINAL DISEASE (CONDITION GIVEN IN PART I)			
17. A. LAST WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 260X		18. DISCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
19. TIME OF INJURY Month, Day, Year 6/26/67		20. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home	
21. I, William J. Harding , certify that (this hospital) attended the deceased from 9 to 9 that was lost 9 and that death occurred at 9 from causes and on the date given above		22. SIGNATURE William J. Harding	
23. PHYSICIAN'S NAME (Type)		24. DATE OF DEATH 6-23-67	
25. B. R. A. R. MOTION (This hospital) attended the deceased from 9 to 9 that was lost 9 and that death occurred at 9 from causes and on the date given above		26. R. A. R. MOTION (This hospital) attended the deceased from 9 to 9 that was lost 9 and that death occurred at 9 from causes and on the date given above	
27. B. R. A. R. MOTION (This hospital) attended the deceased from 9 to 9 that was lost 9 and that death occurred at 9 from causes and on the date given above		28. B. R. A. R. MOTION (This hospital) attended the deceased from 9 to 9 that was lost 9 and that death occurred at 9 from causes and on the date given above	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

07781

CERTIFICATE OF DEATH

07763

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>		d. STREET ADDRESS <u>2100 Lukewood Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Hesse Valerie Harman</u>		4 DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>	
SEX <u>Female</u>	5 COLOR OR RACE <u>Cau</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-19-98</u> 68 FF YRS
10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11 AGE in years, months, and days <u>68</u> YRS <u>6</u> MO <u>19</u> DYS	
12 KIND OF BUSINESS OR INDUSTRY <u>---</u>		13 BIRTHPLACE (County & State or foreign country) <u>British West Indies</u>	
13 FATHER'S NAME <u>John LeFranc</u>		14 MOTHER'S MAIDEN NAME <u>Drew</u>	
15 WAS DECEASED IN ARMED OR NAVAL SERVICE? (Yes, list in unknown; if yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>PHILIP G. HARMAN - Address Patients Chart - Same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> Condition, if any, which gave rise to immediate cause (b) <u>Cerebrovascular thrombosis</u> Underlying cause (c) <u>congestive heart failure with atrial fibrillation</u>			19 PERIOD BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING OR RELATING TO THE IMMEDIATE CAUSE OR UNDERLYING CAUSE <u>---</u>			
20a IDENTIFYING INJURY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II if item 6)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY Home farm locality, street, office bldg, etc.	20f City or town County State
21 I certify that I this hospital attended the deceased from <u>5-14</u> <u>1967</u> to <u>6-3</u> <u>1967</u> and that death occurred at <u>5:35</u> <u>A</u> M. from causes and on the date stated above.			
22a SIGNATURE <u>URBATOY</u>		22b DATE <u>6-3-67</u>	
22c PHYSICIAN'S NAME (Type) <u>J. R. PATDYON</u>		22d ADDRESS <u>6701 N. Charles St, Baltimore</u>	
23a BURIAL REMOVAL SPECIFY <u>Burial</u>	23b DATE <u>6-9-67</u>	23c NAME OF CEMETERY OR REMOVAL ADDRESS <u>Lakeview Memorial</u>	23d CEMETERY CITY OR TOWN COUNTY STATE <u>Eldersburg, Maryland</u>
24 FUNERAL DIRECTOR <u>Ellsworth Armacost 4600 Liberty Hgts. Ave</u>		25a REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Walter J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial permit. Then the funeral director shall have carbon papers. Page 4 and 5 should be filed with the State Dept of Health prior to burial, cremation or removal, and any event within 72 hours after death.



27782

7754

1. PLACE OF BIRTH a. COUNTY BALTIMORE b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town BALTIMORE c. LENGTH OF STAY IN b 6 Days d. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address GREATER BALTO MEDICAL CENTER		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 4800 HADDON AVE. e. IS RESIDENCE ON 4-ARMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SPEDDEN ALWARD HAUSE		4. DATE OF DEATH Month Day Year 6 12 1967	
5. SEX MALE 6. COLOR OR RACE CAU 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/81 9. AGE in years last birthday 85 10. IF UNDER 24 HRS. Month Days Hours Mins	
11. (a) ISSUANCE OF BIRTH CERTIFICATE Give kind of work done during most of working life, even if retired UNKNOWN TOOL DESIGNER (b) KIND OF BUSINESS OR INDUSTRY		12. (a) PLACE (County & State or foreign country) BALTO., MD. (b) COUNTRY OF BIRTH USA	
13. FATHER'S NAME CHARLES HAUSE		14. MOTHER'S MAIDEN NAME WILHELMENIA SEYMOUR	
15. (a) WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; if unknown, fill year gave work or dates of service) UNKNOWN - NO (b) SOCIAL SECURITY NO 317-01-3376		16. (a) ADDRESS MRS. EDWIN HACHTEL - LANGTAY DR. - Glen Arm, Md. (b) HIS HISTORY	
17. (a) CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) 1a. PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHAS D 1b. CHAS D 1c. CHAS D 1d. CHAS D 1e. CHAS D 1f. CHAS D 1g. CHAS D 1h. CHAS D 1i. CHAS D 1j. CHAS D 1k. CHAS D 1l. CHAS D 1m. CHAS D 1n. CHAS D 1o. CHAS D 1p. CHAS D 1q. CHAS D 1r. CHAS D 1s. CHAS D 1t. CHAS D 1u. CHAS D 1v. CHAS D 1w. CHAS D 1x. CHAS D 1y. CHAS D 1z. CHAS D 1aa. CHAS D 1ab. CHAS D 1ac. CHAS D 1ad. CHAS D 1ae. CHAS D 1af. CHAS D 1ag. CHAS D 1ah. CHAS D 1ai. CHAS D 1aj. CHAS D 1ak. CHAS D 1al. CHAS D 1am. CHAS D 1an. CHAS D 1ao. CHAS D 1ap. CHAS D 1aq. CHAS D 1ar. CHAS D 1as. CHAS D 1at. CHAS D 1au. CHAS D 1av. CHAS D 1aw. CHAS D 1ax. CHAS D 1ay. CHAS D 1az. CHAS D 1ba. CHAS D 1bb. CHAS D 1bc. CHAS D 1bd. CHAS D 1be. CHAS D 1bf. CHAS D 1bg. CHAS D 1bh. CHAS D 1bi. CHAS D 1bj. CHAS D 1bk. CHAS D 1bl. CHAS D 1bm. CHAS D 1bn. CHAS D 1bo. CHAS D 1bp. CHAS D 1bq. CHAS D 1br. CHAS D 1bs. CHAS D 1bt. CHAS D 1bu. CHAS D 1bv. CHAS D 1bw. CHAS D 1bx. CHAS D 1by. CHAS D 1bz. CHAS D 1ca. CHAS D 1cb. CHAS D 1cc. CHAS D 1cd. CHAS D 1ce. CHAS D 1cf. CHAS D 1cg. CHAS D 1ch. CHAS D 1ci. CHAS D 1cj. CHAS D 1ck. CHAS D 1cl. CHAS D 1cm. CHAS D 1cn. CHAS D 1co. CHAS D 1cp. CHAS D 1cq. CHAS D 1cr. CHAS D 1cs. CHAS D 1ct. CHAS D 1cu. CHAS D 1cv. CHAS D 1cw. CHAS D 1cx. CHAS D 1cy. CHAS D 1cz. CHAS D 1da. CHAS D 1db. CHAS D 1dc. CHAS D 1dd. CHAS D 1de. CHAS D 1df. CHAS D 1dg. CHAS D 1dh. CHAS D 1di. CHAS D 1dj. CHAS D 1dk. CHAS D 1dl. CHAS D 1dm. CHAS D 1dn. CHAS D 1do. CHAS D 1dp. CHAS D 1dq. CHAS D 1dr. CHAS D 1ds. CHAS D 1dt. CHAS D 1du. CHAS D 1dv. CHAS D 1dw. CHAS D 1dx. CHAS D 1dy. CHAS D 1dz. CHAS D 1ea. CHAS D 1eb. CHAS D 1ec. CHAS D 1ed. CHAS D 1ee. CHAS D 1ef. CHAS D 1eg. CHAS D 1eh. CHAS D 1ei. CHAS D 1ej. CHAS D 1ek. CHAS D 1el. CHAS D 1em. CHAS D 1en. CHAS D 1eo. CHAS D 1ep. CHAS D 1eq. CHAS D 1er. CHAS D 1es. CHAS D 1et. CHAS D 1eu. CHAS D 1ev. CHAS D 1ew. CHAS D 1ex. CHAS D 1ey. CHAS D 1ez. CHAS D 1fa. CHAS D 1fb. CHAS D 1fc. CHAS D 1fd. CHAS D 1fe. CHAS D 1ff. CHAS D 1fg. CHAS D 1fh. CHAS D 1fi. CHAS D 1fj. CHAS D 1fk. CHAS D 1fl. CHAS D 1fm. CHAS D 1fn. CHAS D 1fo. CHAS D 1fp. CHAS D 1fq. CHAS D 1fr. CHAS D 1fs. CHAS D 1ft. CHAS D 1fu. CHAS D 1fv. CHAS D 1fw. CHAS D 1fx. CHAS D 1fy. CHAS D 1fz. CHAS D 1ga. CHAS D 1gb. CHAS D 1gc. CHAS D 1gd. CHAS D 1ge. CHAS D 1gf. CHAS D 1gg. CHAS D 1gh. CHAS D 1gi. CHAS D 1gj. CHAS D 1gk. CHAS D 1gl. CHAS D 1gm. CHAS D 1gn. CHAS D 1go. CHAS D 1gp. CHAS D 1gq. CHAS D 1gr. CHAS D 1gs. CHAS D 1gt. CHAS D 1gu. CHAS D 1gv. CHAS D 1gw. CHAS D 1gx. CHAS D 1gy. CHAS D 1gz. CHAS D 1ha. CHAS D 1hb. CHAS D 1hc. CHAS D 1hd. CHAS D 1he. CHAS D 1hf. CHAS D 1hg. CHAS D 1hh. CHAS D 1hi. CHAS D 1hj. CHAS D 1hk. CHAS D 1hl. CHAS D 1hm. CHAS D 1hn. CHAS D 1ho. CHAS D 1hp. CHAS D 1hq. CHAS D 1hr. CHAS D 1hs. CHAS D 1ht. CHAS D 1hu. CHAS D 1hv. CHAS D 1hw. CHAS D 1hx. CHAS D			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper, pages 1 and 2, and page 4 should be placed in the State Dept. of Health prior to burial. A removal and in any event within 72 hours after death should be filed with the State Dept. of Health.

VIII A 5 4)
250, 1 47)

10-
10-

6-14
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

C7783

CERTIFICATE OF DEATH

C7765

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1, 2, and 3 and show them to the State Dept. of Health prior to burial. Cremation is a removal and is any event with a 24-hour's after death.

PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town." <u>BALTIMORE COUNTY</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER 301 FOURTH STREET</u>		USUAL RESIDENCE (Where deceased lived at institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNAPOLIS</u> c. CITY OR TOWN "If outside corporate limit, write RURAL and give nearest town." <u>ANNAPOLIS</u> d. STREET ADDRESS <u>301 FOURTH STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type of print) First Middle Last <u>ADLAIDE CLORIA HAYES</u> f. DATE OF DEATH Month Day Year <u>JUNE 12 1967</u>		g. AGE IN YEARS h. SEX i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> j. DATE OF BIRTH Month Day Year <u>MARCH 9 1901</u> k. IF MARRIED, YEAR Month Day Year <u>1967</u>	
l. SEX <u>FEMALE</u> m. CIVIL OR RACIAL <u>CAU</u> n. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> o. DATE OF BIRTH Month Day Year <u>MARCH 9 1901</u> p. IF MARRIED, YEAR Month Day Year <u>1967</u>		q. BIRTHPLACE (County & name of foreign country) <u>ANNAPOLIS MD</u> r. CITIZENSHIP <u>U.S.A.</u>	
s. SOCIAL SECURITY NO. <u>212-05-1344</u>		t. INFORMANT <u>Jack Hayes</u> Address # <u>2</u>	
u. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brochial Pneumonia</u> Conditions, if any, which gave rise to immediate cause or, stating the underlying cause DUE TO (b) <u>Carcinoma of the Lung + Metastases</u> DUE TO (c) <u>Hypertension</u>		v. PERIOD OF ILLNESS <u>2 days</u> w. TIME OF DEATH <u>1 year +</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION SHOWN IN PART I)			
20a. AGE AT DEATH WAS UNDERLYING OR OBTAINING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month Day Year Hour p.m. <u>9</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> No While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm Factory street office bldg sh		20f. CITY or town County State	
21. I certify that (1) this hospital attended the deceased from <u>5/30</u> <u>1967</u> to <u>6/12</u> <u>1967</u> that I have just saw the deceased alive on <u>6/12</u> <u>1967</u> and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Derek A Bruce</u>		22b. ADDRESS <u>65 MC</u>	
22c. PHYSICIAN'S NAME TYPE <u>DEREK A. BRUCE</u>		22d. ADDRESS <u>65 MC</u>	
23a. BURIAL REMAINT (MEDICAL OFFICE) <u>Buried</u>		23b. DATE OF BURIAL <u>6-15-67</u>	
23c. NAME OF METEROROLOGICAL <u>St. Mary's</u>		23d. NAME OF METEROROLOGICAL <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR <u>John M. Poyl & Sons Annapolis, Md</u>		25. RECORDED BY <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to be used as the burial transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept at New York to bring remittance a removal and any benefits. Within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

27,66

PLACE OF DEATH a. COUNTY <u>Baltimore</u>		USUAL RESIDENCE (Where deceased lived if different from Residence before admission) c. STATE <u>Maryland</u>	
b. IF DECEASED WAS IN OUTSIDE SEPARATE LIMITS Write RURAL and give nearest town <u>Towson</u>		d. CITY OR TOWN (If outside separate limits write RURAL and give nearest town) <u>Baltimore 21205</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		f. STREET ADDRESS <u>823 N. Luzerne Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sophie P HEROLD</u>		4. DATE OF DEATH Month Day Year <u>June 29, 1967</u>	
5. SEX <u>Female</u>		6. RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 3, 1883</u>	
9. AGE in years last birthday <u>83</u>		10. MONTH OF BIRTH <u>November</u>	
11. PLACE OF BIRTH (County & State or foreign country) <u>Czechoslovakia</u>		12. NATIONALITY <u>USA</u>	
13. FATHER'S NAME <u>FRANK HADLIK</u>		14. MOTHER'S MARRIED NAME <u>Julia HODEK</u>	
15. WA. DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 48 050301</u>	
17. INFORMANT <u>William M. Herold</u>		18. ADDRESS <u>823 N. Luzerne Ave.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY <u>4200 Congestive heart failure</u>		20. IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Indicate if present in past) <u>None</u>		22. WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. A. IDENTIFY WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If other notify medical examiner) <u>None</u>		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of the form) <u>None</u>	
24a. TIME OF INJURY Month Day Year <u>None</u>		24b. NATURE OF INJURY (Home, work, or other) <u>None</u>	
25. I certify that I (this hospital) attended the deceased from <u>June 24, 1967</u> to <u>June 29, 1967</u> that I (we) last saw the deceased alive on <u>June 29, 1967</u> and that death occurred at <u>8:55AM</u> from causes and on the date stated above.		26. SIGNATURE OF PHYSICIAN <u>Ramon P. Lopez</u>	
27. PHYSICIAN'S NAME (Type) <u>Ramon P. Lopez, M.D.</u>		28. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>	
29a. BURIAL (If not, specify) <u>Buried</u>		29b. DATE OF BURIAL <u>7/3/67</u>	
30a. NAME OF CEMETERY OR REPOSITORY <u>Holy Redeem Cemetery</u>		30b. LOCATION (City or Town, County, State) <u>Baltimore, Md.</u>	
31. SIGNATURE OF REGISTRAR <u>Philip E. Crach</u>		32. REGISTRAR'S SIGNATURE <u>Michaela Judge</u>	

1 f

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and led in by the funeral director, page 3 should be delivered to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07785

CERTIFICATE OF DEATH

07767

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. RURAL RURAL		2 USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN Baltimore d. RURAL RURAL	
3 NAME OF DECEASED First Middle Last MARY RUTH HERSOM		4 DATE OF DEATH Month Day Year June 15 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 29, 1919
9 AGE (In years last birthday) 48		10 UNDER 24 HRS. Months Days Hours Mins.	
11 OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12 KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME John Callinan		14 MOTHER'S MAIDEN NAME Ida Brill	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. 215-03-5256	
17 INFORMANT Harold Hersom		Address 1645 Pole's Rd.21	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hemorrhage DUE TO heart attack CONDITIONS (b) hypertension DUE TO arteriosclerosis STATE THE UNDERLYING CAUSE (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)			
20a AFFECTION WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, store, other bldg., etc.)		20f CITY or town (County) (State)	
21 I certify that this hospital attended the deceased from Aug. 1966 to June 96 that () was saw the deceased alive on June 14 1967 and that death occurred at 10:14 P.M. Cause, and on the date stated above.			
22a SIGNATURE Dr. D. William Schlott		22b DATE SIGNED June 16, 1967	
23a RURAL REMAINDER REMOVAL SPECIALTY burial		23b DATE INTERMENT June 19, 1967	
23c NAME OF CEMETERY OR REMAINDER Baltimore National		23d LOCATION (City or town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc.Baltimore, Md.11		25a REC'D BY REGISTRAR DATE June 19 1967	
25b REGISTRAR SIGNATURE Charles Judge			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
77786
CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY **Baltimore** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk** c. LENGTH OF STAY IN b **7 Years** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **1964 Frames Road**

2 USUAL RESIDENCE Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk** d. STREET ADDRESS **1964 Frames Road** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Middle Last **Francis W. Hines** 4 DATE OF DEATH Month Day Year **June 17 1967**

5 SEX **Male** 6 COLOR OR RACE **White** 7 MARRIED ☐ NEVER MARRIED ☒ 8 DATE OF BIRTH **Oct. 7, 1924** 9 AGE (in years last birthday) **42 yrs** 10 FUND 1 YEAR FUND 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY **Goodwill Industries of Balto.** 11 BIRTHPLACE (County & State, or foreign country) **Maryland** 12 CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **William Hines** 14. MOTHER'S MAIDEN NAME **Martha Murphy**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war and dates of service) **No** 16 SOCIAL SECURITY NO. **218-18-2521** 17. INFORMANT (Sister) **Mrs. Donald Lynch, 1964 Frames Rd. Dundalk, Maryland**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Acute heart Failure**
DUE TO **Emphysema**
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **Feb 2 1966** 20d. INJURY OCCURRED while at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory street office bldg, etc.) **20f. (City or town) (County) (State)**

21 I certify that (I) (this hospital) attended the deceased from **Feb 2 1966** to **6/17 1967**, that (I) (we) last saw the deceased alive on **6/17 1967**, and that death occurred at **10A M.** from the causes and on the date stated above.

22a. SIGNATURE **Marcos Levin** 22b. DATE SIGNED **6/17/67**
22c. PHYSICIAN'S NAME (Type) **Marcos Levin** 22d. ADDRESS **M. D. 201 Wise Ave. Dundalk, Md. 21222**

23a. BURIAL, CREMATION, or REMOVAL (Specify) **Burial** 23b. DATE THEREOF **6/20/67** 23c. NAME OF CEMETERY OR CREMATORY **Oak Lawn Cemetery** 23d. LOCATION (City, town or county) (State) **Baltimore, Maryland**

24. FUNERAL DIRECTOR **John J. Duda, 7922 Wise Ave. Dundalk, Md.** 25a. REC'D BY REG. STAFF **DATE JUN 20 1967** 25b. REG. STAFF'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

37787

37763

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be defiled for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or empor, and a copy event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Catonsville c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Baltimore d. STREET ADDRESS 619 North Fulton Avenue e. IF RESIDENCE IN A GRAVE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3 NAME OF DECEASED (Type in print) First Ernest Middle Hinton Last SEX male 6 COLOR OR RACE Negro 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8a. DATE OF BIRTH Aug. 5, 1936 8b. AGE (In years, last birthday) 30 8c. IF UNDER 1 YEAR (Months, Days) 8d. IF UNDER 1 MONTH (Days, Hours, Minutes)		4 DATE OF DEATH Month June Day 14 Year 1967	
10a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000.		11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000.	
5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 3			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

07788

CERTIFICATE OF DEATH

07770

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposition, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTO MARYLAND		2 USUAL RESIDENCE Where deceased lived if institution. Residence before admission b STATE MD c COUNTY BALTO	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CATONSVILLE		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CATONSVILLE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 S Rolling Rd		e STREET ADDRESS 6 S. Rolling Rd	
3 NAME OF DECEASED (Type in print) Edwin Thomas Hobbs Jr		4 DATE OF DEATH Month JUNE Day 9 Year 1967	
a SEX M	b COLOR OR RACE W	c MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	d DATE OF BIRTH July 6, 1906
e AGE in years, months, days 60 yrs		f IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
g S. A. OCCUPATION (Give kind of work done during week of working life even if retired) ENGINEER		h INDUSTRY C&P Telephone Co.	
i BIRTHPLACE (County & State or foreign country) BALTO MD		j IF 21 IN WHAT COUNTRY? U.S.	
k FATHER'S NAME Edwin Thomas Hobbs Sr		l MOTHER'S MAIDEN NAME Rosalie Littlepage	
m WAS HE EVER IN ARMED FORCES? (Yes, no, unknown) (If yes give date of service) NO		n SOCIAL SECURITY NO 212-03-6346	
o INFORMANT KATHRYN Hobbs		p ADDRESS 6 S Rolling Rd	
A CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 1211 DUE TO (c) 1211 DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) 3 INTERNAL OR EXTERNAL CAUSE OF DEATH 3 3 3			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II at item 8)			
20c TIME OF INJURY Month Day Year Hour 9 AM 9 PM		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home, apt, factory, street, office, bldg, etc.		20f City or town County State	
21 I certify that (1) this hospital attended the deceased from 1955 to June 9 1967 that we last saw the deceased alive on June 2 1967 and that death occurred at 5 A M from causes and on the date stated above			
22a SIGNATURE John A. Nesbitt Jr		22b ADDRESS 1009 Frederick Rd Baltimore Md	
23a PHYSICIAN'S NAME Type John A. Nesbitt Jr		23b DATE OF DEATH 6/9/67	
23c NAME OF CITY OR TOWN BALTO MD		23d COUNTY BALTO MD	
23e REC'D BY REGISTRAR 14 1967		23f REGISTRAR'S SIGNATURE John A. Nesbitt Jr	
23g REMOVAL SPECIFY BURIAL		23h DATE OF REMOVAL 6/12/67	
23i FUNERAL DIRECTOR E S Mac Nabb		23j ADDRESS 301 Frederick Rd Baltimore Md	



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial 'transit' permit. Then please remember to file page 1 in the State Dept. of Health and page 2 in the State Dept. of Health and page 3 in the State Dept. of Health and page 4 in the State Dept. of Health.

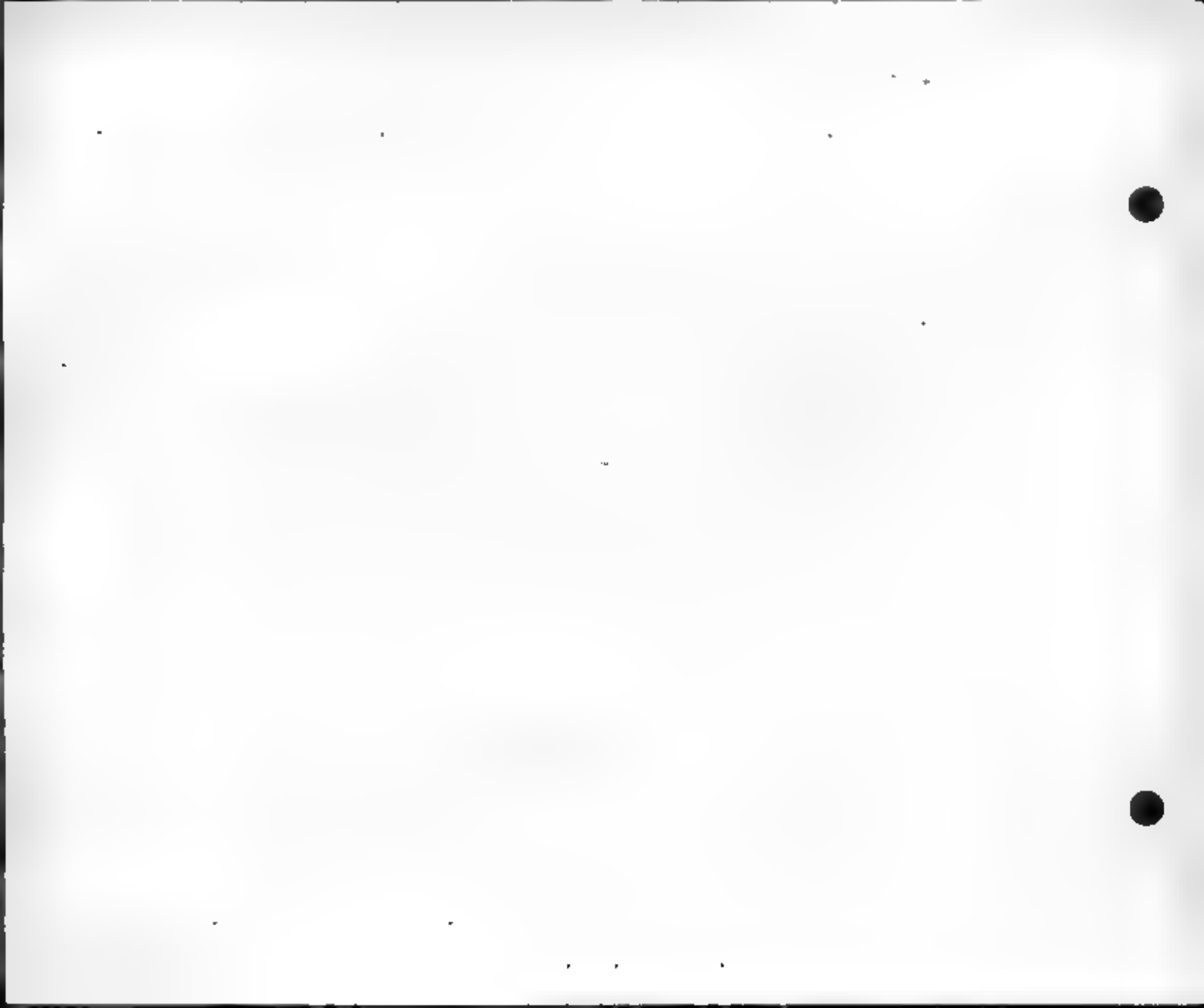
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

97785

CERTIFICATE OF DEATH

37771

PLACE OF DEATH a. COUNTY Balto. MARYLAND		USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 33 Acorn Circle		d. STREET ADDRESS 33 Acorn Circle	
3. NAME OF DECEASED (Type at print) Emma A. Hobbs		4. DATE OF DEATH Month 6 Day 22 Year 1967	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE in years, months, days 83 years
11. FATHER'S NAME Charles Walter		12. MOTHER'S MAIDEN NAME Harriet Poulton	
13. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes give war or dates of service) no		14. SOCIAL SECURITY NO. 218-54-4678	15. INFORMANT W. Leonard Hobbs Address Same
16. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sarcinoma of Breast X DUE TO (b) Conditions, if any, which gave rise to immediate cause, (c), stating the underlying cause last. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) arteriosclerotic cardiac vascular disease			17. INITIAL REPORT WITH OTHER DEATHS 3 from
20a. IDENTIFY DEATH UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item B.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour, Min, P.M. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.	20f. CITY OR TOWN Balto. County (State)
21. I certify that this hospital attended the deceased from March 6 1966 to April 22 1967 that we last saw the deceased alive on March 22 1967 and that death occurred at 7:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE George Sawyer		22b. DATE OF DEATH 6/23/67	
22c. PHYSICIAN'S NAME AND TYPE GEORGE SAWYER, M.D.		22d. ADDRESS 4808 Harford Rd.	
23a. BURIAL INFORMATION BENEFIT (Specify) Burial	23b. DATE OF BURIAL 6/24/67	23c. NAME OF CEMETERY OR REPOSITORY Loudon Park Cem.	23d. LOCATION (City or town, County, State) Balto., Md.
24. FUNERAL HOME Leonard J. Ruck Inc.		25a. REC'D BY REGISTRAR DATE JUN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

077790

07772

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN IF outside corporate limits write RURAL and give nearest town. <u>Baltimore</u>		c. LENGTH OF STAY IN U.S. <u>7 Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address <u>Greater Baltimore Medical Center</u>		e. STREET ADDRESS <u>2916 Erdman Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> , Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1896</u>
9. AGE in years birthday <u>71</u> yrs		10. IF UNDER 1 YEAR Month <u>1</u> Day <u>1</u> Hour <u>1</u> Minute <u>1</u>	
11. a. Usual OCCUPATION Give kind of work done during past year (even if retired) <u>housewife</u>		b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
12. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		13. COUNTRY OF BIRTH <u>USA</u>	
14. FATHER'S NAME <u>McGeeney, Andrew</u>		15. MOTHER'S MAIDEN NAME <u>Hogert</u>	
16. a. Was EVER in U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		b. SOCIAL SECURITY NO. <u>218 03 6760</u>	
17. INFORMANT <u>Patient's Chart</u>		18. ADDRESS <u>---</u>	
19. a. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Primary carcinoma of Liver (Cholangioma), with</u> <u>Metastases.</u> b. <u>---</u> c. <u>---</u> 20. CONDITIONS, if any, which gave rise to immediate cause of death (state the underlying cause) <u>---</u>			
21. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART 1) <u>---</u>			
22. a. IDENTIFY AND INDICATE (by check) CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) 23. a. TIME OF DEATH (Month, Day, Year) Month <u>June</u> Day <u>22</u> Year <u>1967</u> Hour <u>---</u> Minute <u>---</u> Second <u>---</u> 23. b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u> 23. c. CITY OR TOWN <u>---</u> 23. d. COUNTY <u>---</u> 23. e. STATE <u>---</u>			
24. I certify that (a) this hospital attended the deceased from <u>May 3, 1967</u> to <u>June 22, 1967</u> that (b) we last saw the deceased alive on <u>June 22, 1967</u> and that death occurred at <u>7:30 A.M.</u> from a <u>---</u> and on the date stated above			
25. SIGNATURE <u>John E. Adams</u>		26. DATE SIGNED <u>6/22/67</u>	
27. PHYSICIAN'S NAME <u>John E. Adams, M.D.</u>		28. ADDRESS <u>Greater Baltimore Medical Center</u>	
29. BURIAL, REMAINDER, REMOVAL (Specify) <u>---</u>		30. DATE THEREOF <u>---</u>	
31. NAME OF CEMETERY OR CREMATORY <u>San's Valley Cemetery</u>		32. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
33. FUNERAL DIRECTOR <u>---</u>		34. ADDRESS <u>---</u>	
35. REGISTERED BY REGISTRAR <u>---</u>		36. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
37. DATE <u>JUN 27 1967</u>		38. <u>---</u>	

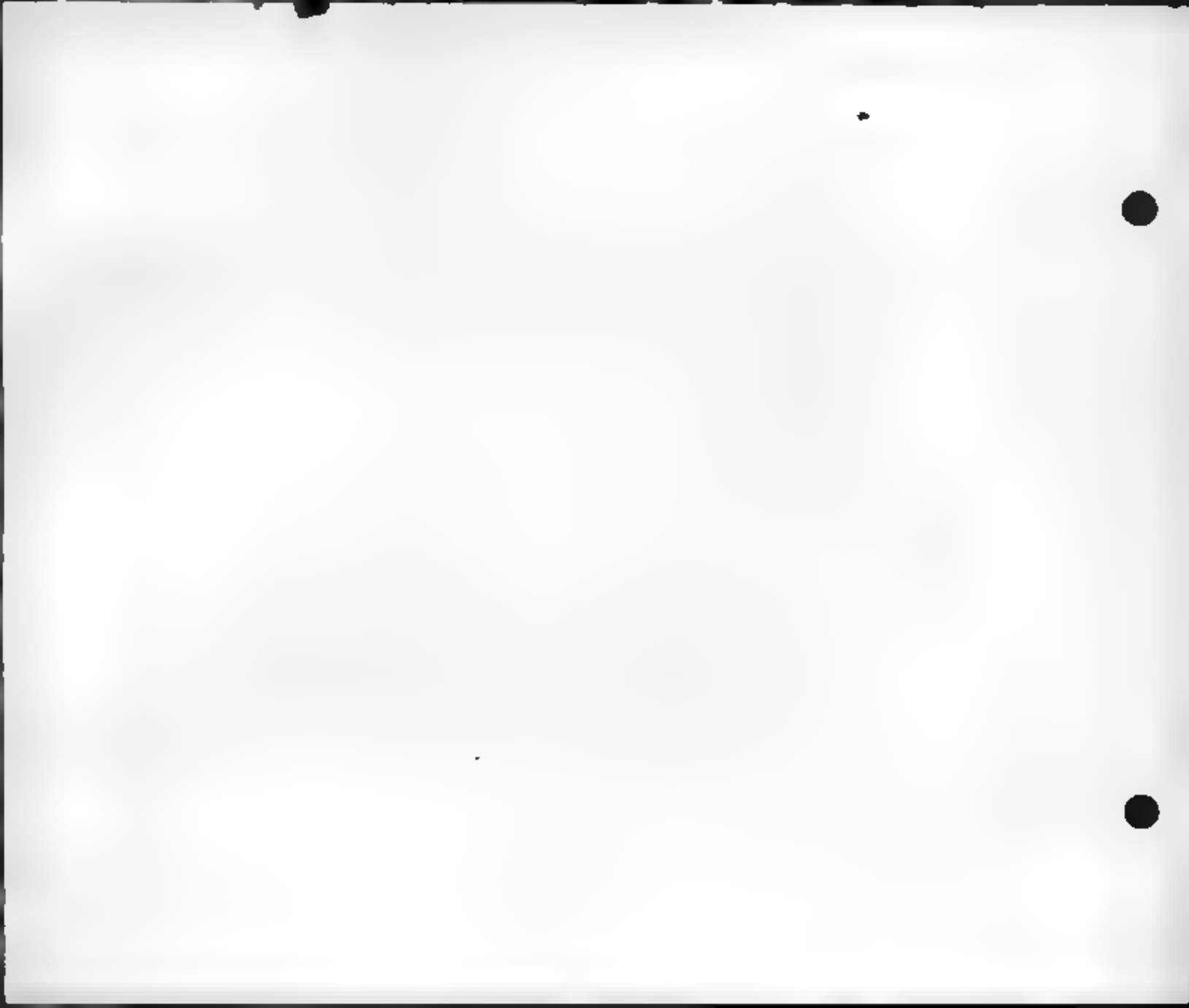


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b <u>Years</u>		2. USUAL RESIDENCE Where deceased lived, if institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> d. STREET ADDRESS <u>10615 York Road</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Vernon</u> Last <u>Hottes</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during mos. of working life, even if retired) <u>Printer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hottes</u>		14. MOTHER'S M maiden NAME <u>Katherine McDonnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-3603A</u>	
17. INFORMANT <u>Mr. James V. Hottes</u>		Address <u>10615 York Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Carcinoma of Pancreas</u> 157X DUE TO (b). Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c).			
PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>Aug. 1938</u> 20d. INJURY OCCURRED <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6-7-1967</u> to <u>10-7-1967</u> , that (I) (we) last saw the deceased alive on <u>6-7-1967</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. H. Siver</u>		22d. ADDRESS <u>3105 N. Charles St. Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jesson Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sparks, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>		25a. REC'D BY REG. CLERK <u>[Signature]</u>	
25b. REC'D BY REG. CLERK <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07792

07771

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE Where deceased lived. Residence before admission a. CITY Maryland b. COUNTY	
b. CITY OR TOWN If outside corporate limit write RURAL and give nearest town Catonsville		c. CITY OR TOWN If outside corporate limit write RURAL and give nearest town Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address Shangri La Home		d. STREET ADDRESS 4603 Leeds Ave. 21229	
3 NAME OF DECEASED (Type or print) First Middle Last Elizabeth C. Houck		4 DATE OF DEATH Month Day Year June 22 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/2/06
9 AGED (In year last birthday) 61 yrs		10 IF UNDER 1 YEAR Month Day Hour Min 61	
11a. OCCUPATION Give kind of work done during most of working life, even if retired Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE Country & state or foreign country Maryland		13 IF OF WHAT COUNTRY? USA	
14 FATHER NAME Merson		15 MOTHER'S MARDEN NAME Mary Krebs	
16 WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes or no or unknown) If yes give war or dates of service No		17 SOCIAL SECURITY NO 216364935	
18 INFORMANT Mr. Albert T. Houck		19 ADDRESS 803 Francis Ave. 21227	
20 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Generalized Metastases Conditions, if any, which gave rise to immediate cause or, stating the underlying cause first (b) Generalized Metastases (c) Generalized Metastases (d) Generalized Metastases (e) Generalized Metastases			
21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Arteriosclerosis			
22a. IDENTIFY UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH b. EITHER WITH MEDICAL EXAMINER			
23a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		25. If any in town, City, State	
26. I certify that the hospital attended the deceased from April 20 1967 to June 22 1967 and that the death occurred at 6:23 PM from causes and on the date stated above			
27. SIGNATURE John C. Healy		28. DATE SIGNED 6/23/67	
29. PHYSICIAN'S NAME (Type or print) John C. Healy		30. ADDRESS 1311 Francis Ave.	
31. BURIAL INFORMATION a. REMOVAL specify Burial		32. DATE TIME OF 6/26/67	
33. NAME OF FUNERARY OR REMOVAL Meadow Ridge Cemetery		34. ADDRESS 21229	
35. FUNERARY DIRECTOR Howard H. Hubbard		36. ADDRESS 4107 Wilkens Ave.	
37. RECEIVED BY REGISTRAR Charles J. Judd		38. DATE JUN 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tag labeled "Page 3" and should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to the burial transit permit. Then please remove urban papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

07793

07775

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) b STATE Md c COUNTY FREDERICK	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		d STREET ADDRESS	
3 NAME OF DECEASED (Type in part) First ELMER Middle TULMAS Last HOUCK		4 DATE OF DEATH Month JUNE Day 17 Year 1967	
a SEX M	b COLOR OR RACE W	c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	d DATE OF BIRTH 10/15/82
e AGE in years last birthday 84		f IF UNDER 1 YEAR Month 1 Day 17 Hours 17 Min 00	
g USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		h BIRTHPLACE (County & State or foreign country) MD	
i FATHER'S NAME PETER HOUCK		j MOTHER'S MARRIED NAME MARY JANE GEESEY	
k WA. DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, OR OTHER U.S. SERVICE (If yes, give war and dates of service)		l SOCIAL SECURITY NO 2-20 5253	
m INFORMANT Records, Mt. Wilson State Hospital		n ADDRESS	
8 CAUSE OF DEATH (Enter only one cause per line for a, b and c) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) 0001 DUE TO FAR ADVANCED PNEUMONIA Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last 0001 DUE TO PART II OTHER IMPORTANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION LIVES IN PART I ARTERIAL CROBIN FURTHER			
9a DISPOSED OF BY BURIAL		9b REMOVED BY 6/21/67	
10a DISPOSED OF BY BURIAL		10b REMOVED BY 6/21/67	
11a DISPOSED OF BY BURIAL		11b REMOVED BY 6/21/67	
12a DISPOSED OF BY BURIAL		12b REMOVED BY 6/21/67	
13a DISPOSED OF BY BURIAL		13b REMOVED BY 6/21/67	
14a DISPOSED OF BY BURIAL		14b REMOVED BY 6/21/67	
15a DISPOSED OF BY BURIAL		15b REMOVED BY 6/21/67	
16a DISPOSED OF BY BURIAL		16b REMOVED BY 6/21/67	
17a DISPOSED OF BY BURIAL		17b REMOVED BY 6/21/67	
18a DISPOSED OF BY BURIAL		18b REMOVED BY 6/21/67	
19a DISPOSED OF BY BURIAL		19b REMOVED BY 6/21/67	
20a DISPOSED OF BY BURIAL		20b REMOVED BY 6/21/67	
21a DISPOSED OF BY BURIAL		21b REMOVED BY 6/21/67	
22a DISPOSED OF BY BURIAL		22b REMOVED BY 6/21/67	
23a DISPOSED OF BY BURIAL		23b REMOVED BY 6/21/67	
24a DISPOSED OF BY BURIAL		24b REMOVED BY 6/21/67	
25a DISPOSED OF BY BURIAL		25b REMOVED BY 6/21/67	
26a DISPOSED OF BY BURIAL		26b REMOVED BY 6/21/67	
27a DISPOSED OF BY BURIAL		27b REMOVED BY 6/21/67	
28a DISPOSED OF BY BURIAL		28b REMOVED BY 6/21/67	
29a DISPOSED OF BY BURIAL		29b REMOVED BY 6/21/67	
30a DISPOSED OF BY BURIAL		30b REMOVED BY 6/21/67	
31a DISPOSED OF BY BURIAL		31b REMOVED BY 6/21/67	
32a DISPOSED OF BY BURIAL		32b REMOVED BY 6/21/67	
33a DISPOSED OF BY BURIAL		33b REMOVED BY 6/21/67	
34a DISPOSED OF BY BURIAL		34b REMOVED BY 6/21/67	
35a DISPOSED OF BY BURIAL		35b REMOVED BY 6/21/67	
36a DISPOSED OF BY BURIAL		36b REMOVED BY 6/21/67	
37a DISPOSED OF BY BURIAL		37b REMOVED BY 6/21/67	
38a DISPOSED OF BY BURIAL		38b REMOVED BY 6/21/67	
39a DISPOSED OF BY BURIAL		39b REMOVED BY 6/21/67	
40a DISPOSED OF BY BURIAL		40b REMOVED BY 6/21/67	
41a DISPOSED OF BY BURIAL		41b REMOVED BY 6/21/67	
42a DISPOSED OF BY BURIAL		42b REMOVED BY 6/21/67	
43a DISPOSED OF BY BURIAL		43b REMOVED BY 6/21/67	
44a DISPOSED OF BY BURIAL		44b REMOVED BY 6/21/67	
45a DISPOSED OF BY BURIAL		45b REMOVED BY 6/21/67	
46a DISPOSED OF BY BURIAL		46b REMOVED BY 6/21/67	
47a DISPOSED OF BY BURIAL		47b REMOVED BY 6/21/67	
48a DISPOSED OF BY BURIAL		48b REMOVED BY 6/21/67	
49a DISPOSED OF BY BURIAL		49b REMOVED BY 6/21/67	
50a DISPOSED OF BY BURIAL		50b REMOVED BY 6/21/67	
51a DISPOSED OF BY BURIAL		51b REMOVED BY 6/21/67	
52a DISPOSED OF BY BURIAL		52b REMOVED BY 6/21/67	
53a DISPOSED OF BY BURIAL		53b REMOVED BY 6/21/67	
54a DISPOSED OF BY BURIAL		54b REMOVED BY 6/21/67	
55a DISPOSED OF BY BURIAL		55b REMOVED BY 6/21/67	
56a DISPOSED OF BY BURIAL		56b REMOVED BY 6/21/67	
57a DISPOSED OF BY BURIAL		57b REMOVED BY 6/21/67	
58a DISPOSED OF BY BURIAL		58b REMOVED BY 6/21/67	
59a DISPOSED OF BY BURIAL		59b REMOVED BY 6/21/67	
60a DISPOSED OF BY BURIAL		60b REMOVED BY 6/21/67	
61a DISPOSED OF BY BURIAL		61b REMOVED BY 6/21/67	
62a DISPOSED OF BY BURIAL		62b REMOVED BY 6/21/67	
63a DISPOSED OF BY BURIAL		63b REMOVED BY 6/21/67	
64a DISPOSED OF BY BURIAL		64b REMOVED BY 6/21/67	
65a DISPOSED OF BY BURIAL		65b REMOVED BY 6/21/67	
66a DISPOSED OF BY BURIAL		66b REMOVED BY 6/21/67	
67a DISPOSED OF BY BURIAL		67b REMOVED BY 6/21/67	
68a DISPOSED OF BY BURIAL		68b REMOVED BY 6/21/67	
69a DISPOSED OF BY BURIAL		69b REMOVED BY 6/21/67	
70a DISPOSED OF BY BURIAL		70b REMOVED BY 6/21/67	
71a DISPOSED OF BY BURIAL		71b REMOVED BY 6/21/67	
72a DISPOSED OF BY BURIAL		72b REMOVED BY 6/21/67	
73a DISPOSED OF BY BURIAL		73b REMOVED BY 6/21/67	
74a DISPOSED OF BY BURIAL		74b REMOVED BY 6/21/67	
75a DISPOSED OF BY BURIAL		75b REMOVED BY 6/21/67	
76a DISPOSED OF BY BURIAL		76b REMOVED BY 6/21/67	
77a DISPOSED OF BY BURIAL		77b REMOVED BY 6/21/67	
78a DISPOSED OF BY BURIAL		78b REMOVED BY 6/21/67	
79a DISPOSED OF BY BURIAL		79b REMOVED BY 6/21/67	
80a DISPOSED OF BY BURIAL		80b REMOVED BY 6/21/67	
81a DISPOSED OF BY BURIAL		81b REMOVED BY 6/21/67	
82a DISPOSED OF BY BURIAL		82b REMOVED BY 6/21/67	
83a DISPOSED OF BY BURIAL		83b REMOVED BY 6/21/67	
84a DISPOSED OF BY BURIAL		84b REMOVED BY 6/21/67	
85a DISPOSED OF BY BURIAL		85b REMOVED BY 6/21/67	
86a DISPOSED OF BY BURIAL		86b REMOVED BY 6/21/67	
87a DISPOSED OF BY BURIAL		87b REMOVED BY 6/21/67	
88a DISPOSED OF BY BURIAL		88b REMOVED BY 6/21/67	
89a DISPOSED OF BY BURIAL		89b REMOVED BY 6/21/67	
90a DISPOSED OF BY BURIAL		90b REMOVED BY 6/21/67	
91a DISPOSED OF BY BURIAL		91b REMOVED BY 6/21/67	
92a DISPOSED OF BY BURIAL		92b REMOVED BY 6/21/67	
93a DISPOSED OF BY BURIAL		93b REMOVED BY 6/21/67	
94a DISPOSED OF BY BURIAL		94b REMOVED BY 6/21/67	
95a DISPOSED OF BY BURIAL		95b REMOVED BY 6/21/67	
96a DISPOSED OF BY BURIAL		96b REMOVED BY 6/21/67	
97a DISPOSED OF BY BURIAL		97b REMOVED BY 6/21/67	
98a DISPOSED OF BY BURIAL		98b REMOVED BY 6/21/67	
99a DISPOSED OF BY BURIAL		99b REMOVED BY 6/21/67	
100a DISPOSED OF BY BURIAL		100b REMOVED BY 6/21/67	

1

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

07794

07793

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN <u>Baltimore</u> c STATE <u>Maryland</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission if not institution) a COUNTY <u>Baltimore</u> b CITY OR TOWN <u>Baltimore</u> c STATE <u>Maryland</u>	
3 NAME OF DECEASED First <u>Albert</u> Middle <u>Sam</u> Last <u>House</u>		4 DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>M</u> COLOR OR RACE <u>Cauc</u> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 DATE OF BIRTH Month <u>9</u> Day <u>8</u> Year <u>1915</u>	
7 DISEASE OR INJURY <u>Myocardial Infarction</u>		8 CAUSE OF DEATH <u>Myocardial Infarction</u>	
9 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		10 STREET ADDRESS <u>3308 Pilgram Avenue</u>	
11 NAME OF FUNERAL HOME <u>Thomas House</u>		12 COUNTRY OF BIRTH <u>U.S.A.</u>	
13 WA DFL ASSE EVER IN U.S. ARMY OR NAVY Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		14 SOCIAL SECURITY NO <u>212-05-3883</u>	
15 INFORMANT <u>Patience Chart</u>		16 ADDRESS <u>William House, wife, above</u>	
17 CAUSE OF DEATH (Part I) a PART DEATH WAS: A-SUB BY IMMEDIATE CAUSE: (a) <u>Myocardial Infarction</u> (b) <u>Pancreatic Tumor</u> (c) <u>lung at</u>		18 INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19 PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS CONDITION GIVEN IN PART I		20 INJURY OR DISEASE CONDITION GIVEN IN PART I	
21a I certify that (if in hospital) attended the deceased from <u>June 11 1967</u> to <u>June 28 1967</u> and that the death occurred on <u>June 28 1967</u> at <u>9:25 AM</u> from causes and on the date stated above.		21b I certify that (if not in hospital) attended the deceased from <u>June 11 1967</u> to <u>June 28 1967</u> and that the death occurred on <u>June 28 1967</u> at <u>9:25 AM</u> from causes and on the date stated above.	
22a PHYSICIAN <u>Ludilina M. Cleyza</u> M.D.		22b ADDRESS <u>35MC-6701 A. Charles St.</u>	
23a NAME OF FUNERAL HOME <u>Schumanek Funeral Home</u>		23b ADDRESS <u>3331 Brehms Lane #13</u>	
24a NAME OF FUNERAL HOME <u>Schumanek Funeral Home</u>		24b ADDRESS <u>3331 Brehms Lane #13</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health. Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07795

CERTIFICATE OF DEATH

7.77

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
3 NAME OF HOSPITAL OR INDEPENDENT HOME (Give street address) 333 HARLEM LANE		4 STREET ADDRESS 1702 PAMUNKEY ST.	
5 NAME OF DECEASED (Type in print) LILLIAN (Lilly) Middle HUME		6 DATE OF DEATH Month JUNE Day 11 Year 1967	
7 SEX FEMALE	8 COLOR OR RACE white	9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH NOV. 22, 1891
11a. USUAL OCCUPATION (Give kind of work done during most of working life except retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
12 BIRTHPLACE (County & State or foreign country) VIRGINIA		13 AGE (In years last birthday) 75	
14 MOTHER (Maiden Name) WILLIAM M. CARNEALE		15 FATHER (Maiden Name) MARIA THOMAS	
16a. DISEASES EVER IN ARMED FOR US (If yes, give war or dates of service) NO		16b. SOCIAL SECURITY NO. 212-52-1671	
17 INFORMANT DANIEL HUME		18 ADDRESS 216 OSBIRNE AVE.	
19 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY a. IMMEDIATE CAUSE (1) Gram Negative Bacteremia (Septic) b. Uremic Toxin Intoxication c. Chronic Brain Syndrome			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (GIVEN IN PART I) Chronic Brain Syndrome			
20a. ALL IDENTIFYING UNDERLYING OR CONTRIBUTING CAUSES OF DEATH (IF OTHER THAN MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 8.)	
21. TIME OF INJURY Month: Day: Year Hour: a.m. p.m.	22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work <input type="checkbox"/> at work <input type="checkbox"/>	23. PLACE OF INJURY Home <input type="checkbox"/> farm <input type="checkbox"/> factory <input type="checkbox"/> street <input type="checkbox"/> office <input type="checkbox"/> bldg <input type="checkbox"/> etc.	24. (City or town) (County) (State)
25. I certify that this hospital attended the deceased from 4-2-1966 to 6-11-1967 that we last saw the deceased alive on 6-11-1967 and that death occurred at 11:20 P.M. from causes and on the date stated above			
26. SIGNATURE Cesar Valle Carero		27. DATE SIGNED 6-12-67	
28. PHYSICIAN'S NAME (Type) CEsar VALLE CARERO		29. ADDRESS 2027 Liberty Rd	
30a. BURIAL CREMATION, etc. (Specify)	30b. DATE THEREOF	30c. NAME OF CEMETERY OR CREMATORY	30d. LOCATION (City or town) (County) (State)
BURIAL 6-1-67			Md.
31. FUNERAL DIRECTOR Francis W. Schwaab Funeral Home		32. REGISTRAR'S SIGNATURE Charles Judge	
33. ADDRESS Francis W. Schwaab 2101 Frederick Ave.		34. DATE JUN 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon pages 1 and 2 and file them with the State Dept. of Health. The funeral director should be filed with the State Dept. of Health.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

27796

67778

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE Where deceased lived, if institution; Residence before admission)
a. STATE b. COUNTY

Maryland

Baltimore

b. CITY OR TOWN (If outside corporate limits, write R. R. and give nearest town)
Parkville

c. LENGTH OF STAY in lb

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville - 21234

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

7815 Daniel Avenue

d. STREET ADDRESS

7815 Daniel Avenue

15. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type as printed)

OTTILLIE INGE HUPFELD

4. DATE OF DEATH

June 20, 1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

March 1, 1894

9. AGE (In years, months, days, hours, minutes)
73 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry G. Revier

14. MOTHER'S MAIDEN NAME

Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)

no

16. SOCIAL SECURITY NO.

212-09-9719B

17. INFORMANT

Mr. Howard F. Hupfeld-7815 Daniel Ave.

18. CAUSE OF DEATH (Enter only one cause per line in a, b, and c)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Arteriosclerosis of heart

DUE TO

Condition: if any which gave rise to immediate cause
a) stating the underlying cause last

DUE TO

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I a. Part II if from 18)

20c. TIME OF INJURY (Month, Day, Year, Hour, a.m., p.m.)

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)

20f. City or town.

County

State

21. I certify that (I) (hus/husband) attended the deceased from Sept 1946 to 6/20 1967 and saw the deceased alive on 5/21 1967 and the death occurred at 2:45 PM from the cause, and on the date stated above.

22a. SIGNATURE

Nathan Janney

M.D.

ATTENDING PHYS ☒

MED. DIRECTOR ☐

STAFF PHYS ☐

22b. DATE SIGNED 6/21/67

22c. PHYSICIAN'S NAME (Type)

Nathan Janney, M.D.

22d. ADDRESS

7101 Harford Road

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

June 23, '67

23c. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

23d. LOCATION (City, town, or county)

Baltimore City, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

H. Sander & Sons, Inc., Baltimore, Md.

ADDRESS

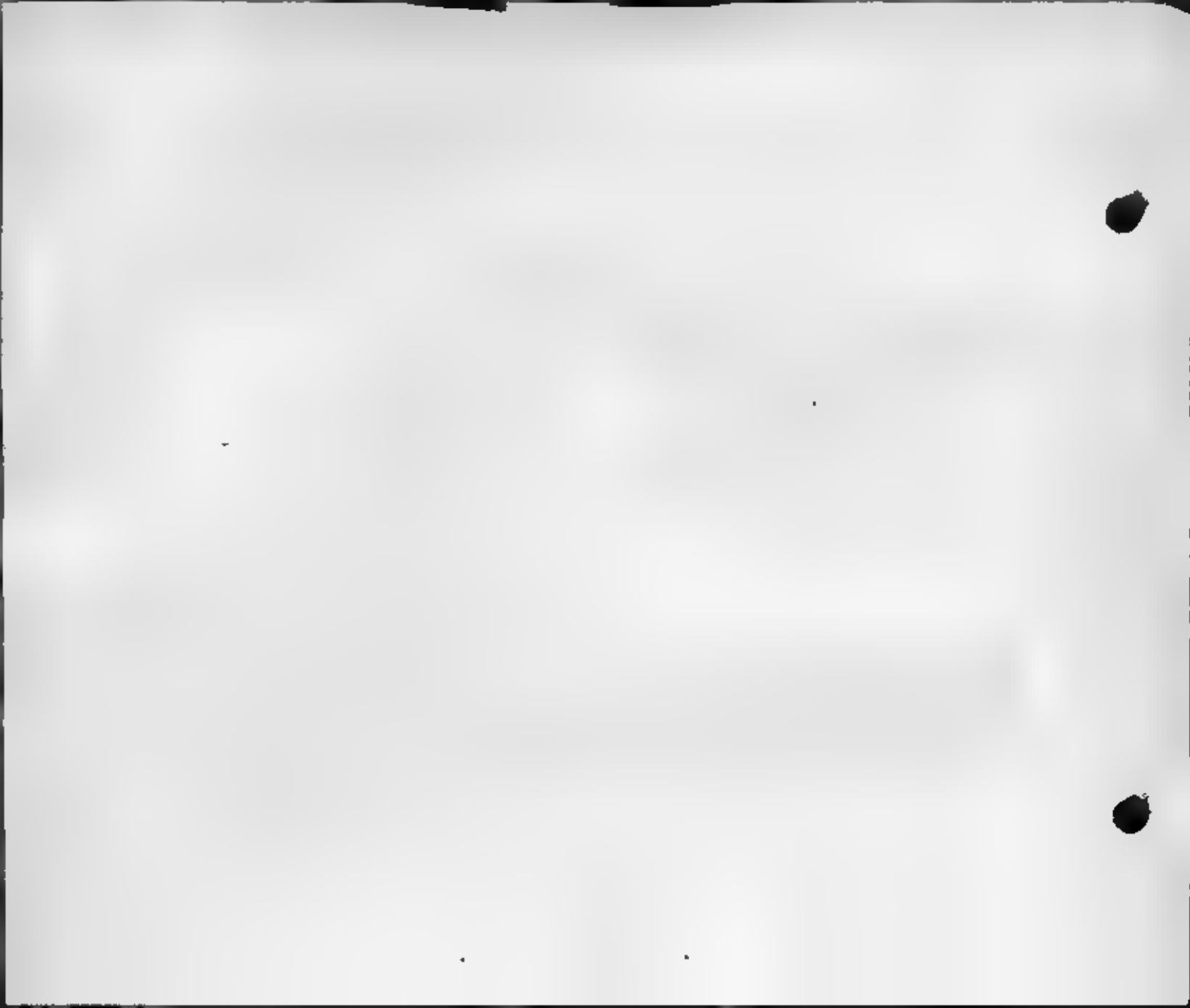
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 23 1967

W. J. Jones, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or duly qualified person, it shall be detached to use as the burial transit permit. There please remove and retain pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

07797

CERTIFICATE OF DEATH

07797

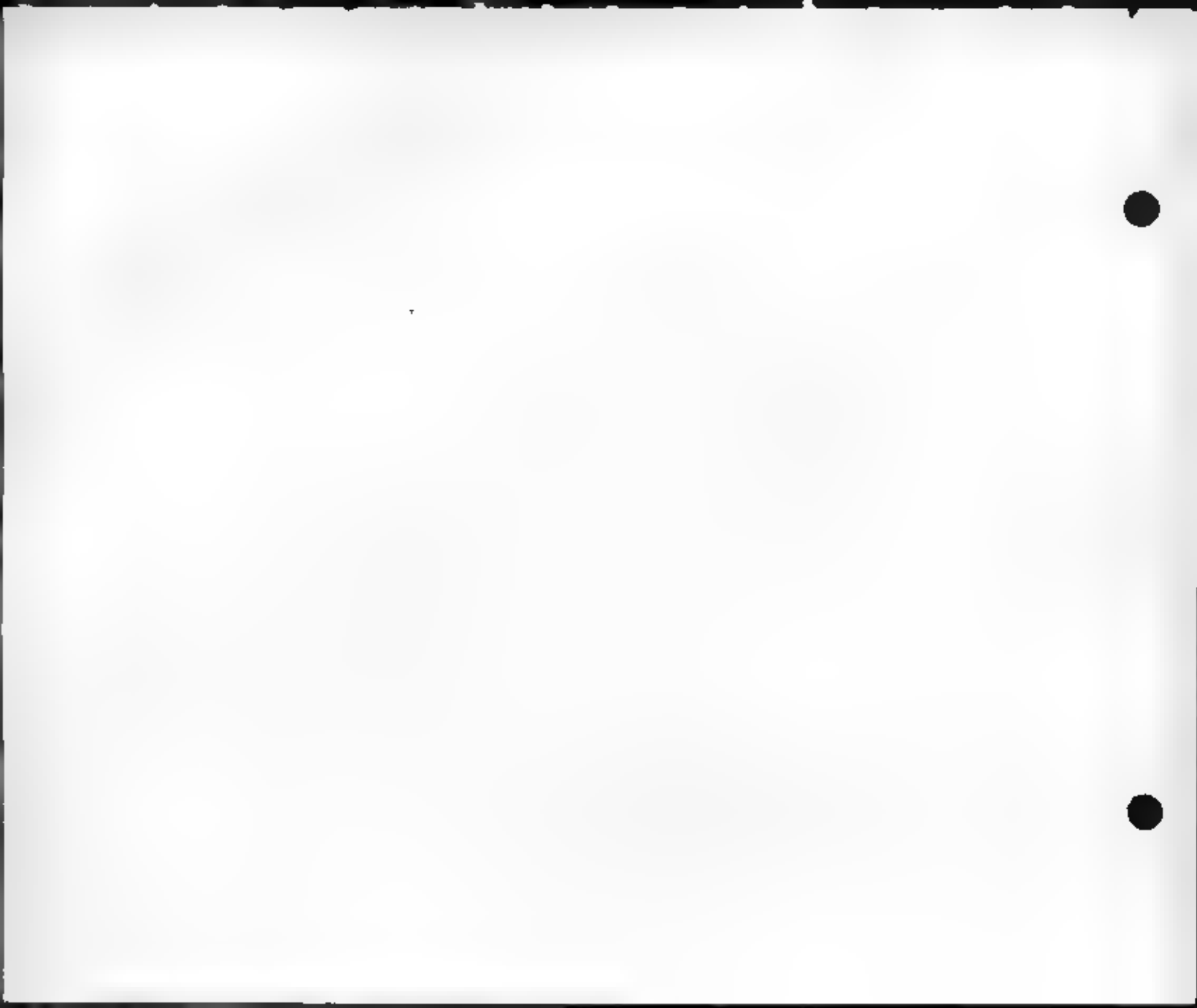
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Stevenson		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Stevenson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Valley Road		e. STREET ADDRESS Valley Road (Venture)	
3. NAME OF DECEASED (Type in print) Catharine Bond Jackson		4. DATE OF DEATH Month June Day 20 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1893
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		9b. KIND OF BUSINESS OR INDUSTRY Own Home	9c. BIRTHPLACE (County & State or foreign country) Baltimore, Md.
3. FATHER'S NAME Hugh Lenox Bond		4. MOTHER'S MAIDEN NAME Jessie VanRennsler	
5. WA, OF, ARMED FORCES (Yes, no, or unknown) (If yes give unit or dates of service) No		6. SOCIAL SECURITY NO. No	
7. INFORMANT Richard N. Jackson, Jr.		8. ADDRESS (Same)	
9. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease (b) Due to (c) Due to Conditions, if any, which gave rise to immediate cause or stating the underlying cause lost.		IN R. & B. BETWEEN ONSET AND DEATH 7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Pulmonary emphysema		10. WA, OF, ARMED FORCES (Yes, no, or unknown) (If yes give unit or dates of service) No	
20a. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20d. CITY or town (County) (State) Pikesville, Md.	
21. I certify that (this hospital) attended the deceased from 948 to June 20 1967 and that death occurred at 11 A.M. from cause, and on the date stated above.			
22a. SIGNATURE Paul H. Royse M.D.		22b. DATE SIGNED 21 June 67	
22c. PHYSICIAN'S NAME (Type) Dr. Paul H. Royse		22d. ADDRESS Pikesville, Md.	
23a. BURIAL REMAINDER R. M. O. (Type) Burial	23b. DATE HEREOF 6/22/1967	23c. NAME OF CEMETERY OR CREMATORY St. Thomas	23d. LOCATION (City or town) (County) (State) Garrison Forest, Md.
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25. ADDRESS 4905 York Rd. Balto. 12, Md.	
26. REF. BY REGISTER 23 1967		27. REF. BY REGISTER Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and may event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and may event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
77798					CERTIFICATE OF DEATH					07750									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNSON</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pow on, Anco Co.</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>522 Castle Drive</u>					d. STREET ADDRESS <u>522 Castle Drive</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>ELROY FENLICK JR</u>					4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1967</u>														
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>June 2, 1893</u>					9. AGE (In years, last birthday) <u>74</u> yrs					10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lock tender</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Md.</u>									
12. C. TIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Charles Lee Jenkins</u>					14. MOTHER'S MAIDEN NAME <u>Ella Ford</u>									
15. WAS DECEASED EVER IN ARMED FORCES? Yes, no or unknown <u>no</u> <u>WW-1</u>					16. SOCIAL SECURITY NO. <u>215-03-9088A</u>					17. INFORMANT <u>Mrs. Julian W. Jenkins</u> Address <u>522 Castle Drive</u>									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Chronic coronary vascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 to 7 yrs</u>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <u>Chronic coronary vascular disease</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? IF OTHER, NOTIFY MEDICAL EXAMINER					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)														
20c. TIME OF INJURY Month Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)									
20f. (City or town)					20g. (County)					20h. (State)									
21. I certify that I (this hospital) attended the deceased from <u>Oct 26, 1954</u> to <u>June 17, 1967</u> , that I (we) last saw the deceased alive on <u>Apr. 7, 1967</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Fred. Vollmer, M.D.</u>										22b. DATE SIGNED <u>6-9-67</u>									
22c. PHYSICIAN'S NAME (Type) <u>Fred. Vollmer, M.D.</u>										22d. ADDRESS <u>6100 York Rd., Baltimore, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>6/20/67</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Walt. Nat'l Cem.</u>									
23d. LOCATION (City, town or county) <u>Baltimore</u>					23e. (State) <u>Md.</u>														
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld</u>										25a. REC'D BY REGISTRAR <u>20 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on reverse. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 14
15M 4 64

07783

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07781

1. PLACE OF DEATH a. COUNTY <u>III C.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) c. LENGTH OF STAY IN 15 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Casapeake Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MARYLAND</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>11</u> d. STREET ADDRESS <u>0 Greenway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>David</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) <u>67</u>		9. DATE OF BIRTH <u>Oct. 2, 1900</u>		10. FUNDING YEAR IF UNDER 24 HRS Months <u>06</u> Days <u>07</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Austin Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Lowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-44-3394</u>		17. INFORMANT: Sister-in-law Address <u>City.</u> <u>Mrs. Lou L. Jenkins, 14 W. Cold Spring Lane</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, pulmonary edema</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>Arteriosclerosis, severe, generalized (age 90)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-24 hrs.</u> <u>15 plus yrs.</u> <u>?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema, severe</u> <u>15 plus years</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18			
20c. TIME OF INJURY Month, Day Year Hour <u>10</u> a.m. <u>10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	
20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <u>October 1950</u> to <u>June 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 15, 1967</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>B. H. Rutledge, M.D.</u>		22b. DATE SIGNED <u>6/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. H. Rutledge, M.D.</u>		22d. ADDRESS <u>18 E. Eager St., Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR <u>Stewart</u>		25a. REC'D BY REGISTRAR <u>June 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



07800

27132

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the funeral director, it will be filed in by the local health department. Then please remove certain papers. Page 1 and 2 should be placed in the burial-transit permit. Then please remove certain papers. Pages 3 and 4 should be placed in the State Death Certificate. The burial certificate and removal and entry event at 1-2 hours after death should be filed with the State Death Certificate.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

07801

07133

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN <u>Essey</u> c. RURAL OR SUBURBAN <u>Life</u>		2. USUAL RESIDENCE Where deceased lived if usual residence before admission a. STATE <u>MD</u> b. CITY OR TOWN <u>Essey</u> c. RURAL OR SUBURBAN <u>Life</u>	
3. NAME OF HOSPITAL OR INSTITUTE If no hospital give street address <u>1643 Hyspell Ave</u>		4. STREET ADDRESS <u>1643 Hyspell Ave</u>	
5. NAME OF DECEASED Type of name <u>FRANK JOHNSON</u>		6. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
7. SEX <u>Male</u>	8. COLOR OR RACE <u>Caucasian</u>	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH <u>April 17 1904</u>
11. OCCUPATION Give full work done during past working life even if retired <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Farmville Va</u>	
13. A. NAME <u>Pleasant Johnson</u>		B. NAME <u>Gannie</u>	
14. WAS DECLARED EVER IN U.S. ARMED FORCES (Yes, no or unknown) If yes give date of service		15. SOCIAL SECURITY NO.	
16. CAUSE OF DEATH (Enter only one cause per part and for all parts) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>Malnutrition & dehydration</u> DUE TO underlying cause which gave rise to immediate cause of stating the underlying cause lost DUE TO (c) <u>Rheumatoid Arthritis</u>		17. INFORMANT <u>Charles Johnson</u> Address <u>1643 Hyspell Ave</u>	
18. CERTIFY that the cause of death stated above is based on a proper medical examination and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unnatural <input type="checkbox"/>		19. SIGNATURE OF MEDICAL EXAMINER <u>Theo C. Patterson</u>	
20. SIGNATURE OF FUNERAL DIRECTOR <u>Marvin E. Clark</u>		21. DATE SIGNED <u>6/24/67</u>	
22. NAME OF CEMETERY OR BURIAL PLACE <u>Greenwood</u>		23. ADDRESS <u>1129 N. E. 1st St</u>	
24. DATE OF BURIAL <u>June 22, 1967</u>		25. DATE OF DEATH <u>JUN 29 1967</u>	

TO DEPUTY MEDICAL EXAMINER

This certificate should be executed within 24 hours after death. If delay is necessary, please explain the reason for the delay in writing the word "pending" in pencil in Item 8. Give Pages 2 and 3 to the funeral director. Pages 4 and 5 may be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, removal or cremation and return any event within 72 hours after death.



2 USUAL RESIDENCE Where detained lived If institution Residence before admission
• STATE Calif b. COUNTY B.L.

4 CITY OF TOWN H. outside of the city limits with RJRAI and a va nated fume

25. Resolving the
On a Farm

Exy Y64

16 AUG 18 JNDSE 44 HRS

12. TON OF WHAT COUNTRY?

M. MÖRNER, H. WIDENMAN

DEPT. OF HEALTH

Strangulation by hanging ~~sudden~~

DUE TO


ION'S CONTRIB TION TO DEATH BUT NOT RELATED TO THE 7 MINUTE. THIS ASSESSMENT WAS GIVEN IN PART 1(a) 12. WAS A 100%.

204. DESCRIBE HOW INJURY OCCURRED Ent

5.

2) I certify that the charges of the remains described above held an Autopsy ☐ inspection ☐ inquiry ☐ and in my opinion death resulted from ☒ Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ASPIRANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER 

Country	State
---------	-------

Funeral Director

REC. 57848, 57849, 57850, 57851, 57852, 57853, 57854, 57855, 57856, 57857, 57858, 57859, 57860, 57861, 57862, 57863, 57864, 57865, 57866, 57867, 57868, 57869, 57870, 57871, 57872, 57873, 57874, 57875, 57876, 57877, 57878, 57879, 57880, 57881, 57882, 57883, 57884, 57885, 57886, 57887, 57888, 57889, 57890, 57891, 57892, 57893, 57894, 57895, 57896, 57897, 57898, 57899, 57900, 57901, 57902, 57903, 57904, 57905, 57906, 57907, 57908, 57909, 57910, 57911, 57912, 57913, 57914, 57915, 57916, 57917, 57918, 57919, 57920, 57921, 57922, 57923, 57924, 57925, 57926, 57927, 57928, 57929, 57930, 57931, 57932, 57933, 57934, 57935, 57936, 57937, 57938, 57939, 57940, 57941, 57942, 57943, 57944, 57945, 57946, 57947, 57948, 57949, 57950, 57951, 57952, 57953, 57954, 57955, 57956, 57957, 57958, 57959, 57960, 57961, 57962, 57963, 57964, 57965, 57966, 57967, 57968, 57969, 57970, 57971, 57972, 57973, 57974, 57975, 57976, 57977, 57978, 57979, 57980, 57981, 57982, 57983, 57984, 57985, 57986, 57987, 57988, 57989, 57990, 57991, 57992, 57993, 57994, 57995, 57996, 57997, 57998, 57999, 58000, 58001, 58002, 58003, 58004, 58005, 58006, 58007, 58008, 58009, 58010, 58011, 58012, 58013, 58014, 58015, 58016, 58017, 58018, 58019, 58020, 58021, 58022, 58023, 58024, 58025, 58026, 58027, 58028, 58029, 58030, 58031, 58032, 58033, 58034, 58035, 58036, 58037, 58038, 58039, 58040, 58041, 58042, 58043, 58044, 58045, 58046, 58047, 58048, 58049, 58050, 58051, 58052, 58053, 58054, 58055, 58056, 58057, 58058, 58059, 58060, 58061, 58062, 58063, 58064, 58065, 58066, 58067, 58068, 58069, 58070, 58071, 58072, 58073, 58074, 58075, 58076, 58077, 58078, 58079, 58080, 58081, 58082, 58083, 58084, 58085, 58086, 58087, 58088, 58089, 58090, 58091, 58092, 58093, 58094, 58095, 58096, 58097, 58098, 58099, 58100, 58101, 58102, 58103, 58104, 58105, 58106, 58107, 58108, 58109, 58110, 58111, 58112, 58113, 58114, 58115, 58116, 58117, 58118, 58119, 58120, 58121, 58122, 58123, 58124, 58125, 58126, 58127, 58128, 58129, 58130, 58131, 58132, 58133, 58134, 58135, 58136, 58137, 58138, 58139, 58140, 58141, 58142, 58143, 58144, 58145, 58146, 58147, 58148, 58149, 58150, 58151, 58152, 58153, 58154, 58155, 58156, 58157, 58158, 58159, 58160, 58161, 58162, 58163, 58164, 58165, 58166, 58167, 58168, 58169, 58170, 58171, 58172, 58173, 58174, 58175, 58176, 58177, 58178, 58179, 58180, 58181, 58182, 58183, 58184, 58185, 58186, 58187, 58188, 58189, 58190, 58191, 58192, 58193, 58194, 58195, 58196, 58197, 58198, 58199, 58200, 58201, 58202, 58203, 58204, 58205, 58206, 58207, 58208, 58209, 58210, 58211, 58212, 58213, 58214, 58215, 58216, 58217, 58218, 58219, 58220, 58221, 58222, 58223, 58224, 58225, 58226, 58227, 58228, 58229, 58230, 58231, 58232, 58233, 58234, 58235, 58236, 58237, 58238, 58239, 58240, 58241, 58242, 58243, 58244, 58245, 58246, 58247, 58248, 58249, 58250, 58251, 58252, 58253, 58254, 58255, 58256, 58257, 58258, 58259, 58260, 58261, 58262, 58263, 58264, 58265, 58266, 58267, 58268, 58269, 58270, 58271, 58272, 58273, 58274, 58275, 58276, 58277, 58278, 58279, 58280, 58281, 58282, 58283, 58284, 58285, 58286, 58287, 58288, 58289, 58290, 58291, 58292, 58293, 58294, 58295, 58296, 58297, 58298, 58299, 58300, 58301, 58302, 58303, 58304, 58305, 58306, 58307, 58308, 58309, 58310, 58311, 58312, 58313, 58314, 58315, 58316, 58317, 58318, 58319, 58320, 58321, 58322, 58323, 58324, 58325, 58326, 58327, 58328, 58329, 58330, 58331, 58332, 58333, 58334, 58335, 58336, 58337, 58338, 58339, 58340, 58341, 58342, 58343, 58344, 58345, 58346, 58347, 58348, 58349, 58350, 58351, 58352, 58353, 58354, 58355, 58356, 58357, 58358, 58359, 58360, 58361, 58362, 58363, 58364, 58365, 58366, 58367, 58368, 58369, 58370, 58371, 58372, 58373, 58374, 58375, 58376, 58377, 58378, 58379, 58380, 58381, 58382, 58383, 58384, 58385, 58386, 58387, 58388, 58389, 58390, 58391, 58392, 58393, 58394, 58395, 58396, 58397, 58398, 58399, 58400, 58401, 58402, 58403, 58404, 58405, 58406, 58407, 58408, 58409, 58410, 58411, 58412, 58413, 58414, 58415, 58416, 58417, 58418, 58419, 58420, 58421, 58422, 58423, 58424, 58425, 58426, 58427, 58428, 58429, 58430, 58431, 584

VS. AUMI

AM 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to file as the burial-transit permit. Then please return the original papers, Pages 1 and 2, to the funeral home. The original should be filed with the State Department of Health prior to burial, cremation or removal and in any case within 72 hours of death.

VA 3-3
25X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07803

CERTIFICATE OF DEATH

67735

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN IF OUTSIDE CORPORATE LIMITS write RURAL and give nearest town FORT HOWARD		2 USUAL RESIDENCE Where deceased lived if married or Residence before admission a. STATE MARYLAND b. COUNTY	
3 NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address VETERANS ADMINISTRATION HOSPITAL		4 DATE OF DEATH Month JUNE Day 23 Year 67	
5 NAME OF DECEASED (Type or print) First VERNON Middle A. Last JOYCE		6 DATE OF BIRTH APRIL 3, 1906	
7 SEX MALE COLOR OR RACE WHITE		8 AGE At last birthday 61	
9 OCCUPATION Give kind of work done during past year, working life, even if retired ROOFER		10 BIRTHPLACE County & State or foreign country BALTIMORE, MARYLAND	
11 FATHER'S NAME WILLIAM JOYCE		12 MOTHER'S MAIDEN NAME ELLA CLARDY	
13 WAS DECEASED ARMED FOR SERVICE? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give kind of service) WW II		14 ADDRESS 218 05 05 89 CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
15 CAUSE OF DEATH (Type or print) (If more than one, give the one which caused death first) BRONCHOPNEUMONIA		16 NATURE OF DEATH 9 DAYS	
17 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART 15) PARAPLEGIA DUE TO METASTASIS TO THE SPINE		18 NATURE OF DEATH 2 YEARS +	
19 I certify that this hospital attended the deceased from 5/25/67 to 6/23/67 and that the death occurred at 2:45 PM from causes and on the date stated above.		20 SIGNATURE OF PHYSICIAN PETER V. JUVAN, M. D.	
21 PHYSICIAN'S NAME (Type or print) PETER V. JUVAN, M. D.		22 ADDRESS VAH FORT HOWARD, MARYLAND	
23 BURIAL (Type or print) BURIAL		24 NAME OF FUNERAL HOME OR REMAINER MEADOWRIDGE CEMETERY	
25 NAME OF FUNERAL HOME OR REMAINER MC CULLY FUNERAL HOME		26 REGISTRAR'S SIGNATURE Charles Judge	

JUN 26 1967



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07804

CERTIFICATE OF DEATH

C7786

1 PLACE OF DEATH a. <u>Baltimore</u> b. CITY OR TOWN IF outside corporate limits write Rural and give nearest town <u>Baltimore</u>		c. LENGTH OF DAY IN E <u>50yrs.</u>		2 USUAL RESIDENCE Where deceased lived. If institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY	
3 NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address <u>St Joseph Hospital</u>			d. STREET ADDRESS <u>3200 batavia Ave.</u>		e. RESIDENCE ON 2nd ARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED Type or print First <u>Paul</u> Middle <u>F.</u> Last <u>Kalkhof</u>		4 DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/8/1889</u>	9 AGE in years last birthday <u>78</u>	IF UNDER 24 HRS. Month Days Hours Min
10a. SOURCE OF INFORMATION Give kind of work done during last working life <u>Retired Ad. Mgr.</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Oil Co.</u>		11 BIRTHPLACE (County & State or foreign country) <u>New York</u>	
12 FATHER'S NAME <u>August Kalkhof</u>			13 MOTHER'S MAIDEN NAME <u>Bertha Mueller</u>		
14 WAS DECEASED EVER IN ARMED FORCES? (If yes give year and dates of service) <u>Unk.</u>		15 SOCIAL SECURITY NO. <u>212-01 0077A</u>		16 INFORMANT Name <u>Mr. ...</u> Address <u>...</u>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART DEATH WAS CAUSED BY IMMEDIATE DUE TO <u>Terminal Carcinomatosis (Primary in Lung)</u> Conditions, if any, which gave rise to immediate cause of stating the underlying cause lost. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND IOM GIVEN IN PART 17					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. IF IDENTIFYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 of item 8.			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>9</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY Home, farm, factory, street, office bldg. etc.		20f. (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <u>5/11/1967</u> to <u>6/7/1967</u> that (I, we) last saw the deceased alive on <u>6/7/1967</u> and that death occurred at <u>8:25 PM</u> from causes and on the date stated above					
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>June 8, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23a. BURIAL REMOVAL, REMOVAL (Specify) <u>1-11-1</u>		23b. DATE THEREOF <u>June 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cl. ...</u>	
24 FUNERAL DIRECTOR <u>[Signature]</u>		24b. ADDRESS <u>...</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and camp etely filed in by the time a direct a page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health in prior to burial, cremation or removal and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27787

27805

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please move carbon paper to page 3 and detach page 3. Page 3 should be detached for use as the burial-transit permit. Then please move carbon paper to page 4 and detach page 4. Page 4 should be filed in the State Dept of Health prior to burial, cremation or removal of any event within 72 hours of the death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN TB <u>3 months</u>		2 USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Strong's State Hospital</u>		d. STREET ADDRESS <u>208 Ramsey Street</u>	
3 NAME OF DECEASED a. First name <u>John</u> b. Middle name <u>Kenneth</u> c. Last name <u>Kanely</u>		4 DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JANUARY 25, 1886</u>
9 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Soldier</u>		10 KIND OF BUSINESS OR INDUSTRY <u>Brush Mfg</u>	11 BIRTHPLACE (County & State & high country) <u>Maryland</u>
12 FATHER'S NAME <u>John Kanely</u>		13 MOTHER'S MAIDEN NAME <u>KATHERINE GAGER</u>	
14 WAS DECEASED EVER IN ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) <u>No</u>		15 SOCIAL SECURITY NO. <u>23-45-2971A</u>	
16 CAUSE OF DEATH (Enter on one cause per line for (a) 1b. and 1c. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>193X</u> DUE TO <u>17</u> Conditions if any which gave rise to immediate cause (b) <u>18</u> Violating the underlying cause (c) <u>19</u>		18 INTERVA. BETWEEN ONX AND DIAH <u>19</u>	
19 PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART 16) <u>20</u>		21 WAS A P.P.M.V. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. TIME OF INJURY Month Day Year <u>March 7 1967</u>		22b. INJURY OR ILLNESS While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
23a. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>		23b. CITY OR TOWN <u>Baltimore</u>	
24 I certify that (1) this hospital attended the deceased from <u>March 7 1967</u> to <u>June 10 1967</u> that we last saw the deceased a few days before <u>June 10 1967</u> and that death occurred at <u>5:30 PM</u> from causes and on the date stated above.			
25a. SIGNATURE <u>John Kanely</u>		25b. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> TAF. PHYS. <input checked="" type="checkbox"/>	
26 PHYSICIAN'S NAME <u>John Kanely</u>		27 ADDRESS <u>Baltimore, Maryland 21208</u>	
28a. BURIAL OR CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>	28b. DATE OF BURIAL OR CREMATION <u>6-13-67</u>	28c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>	28d. LOCATION (City or Town, County, State) <u>Baltimore, Md.</u>
29a. R-1 BY REGISTRAR <u>John Kanely</u>		29b. R-1 BY REGISTRAR <u>John Kanely</u>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER This certificate should be examined within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Place a tag with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation or removal and in any event within 48 hours after death.

VS A15ME
AM 1/66

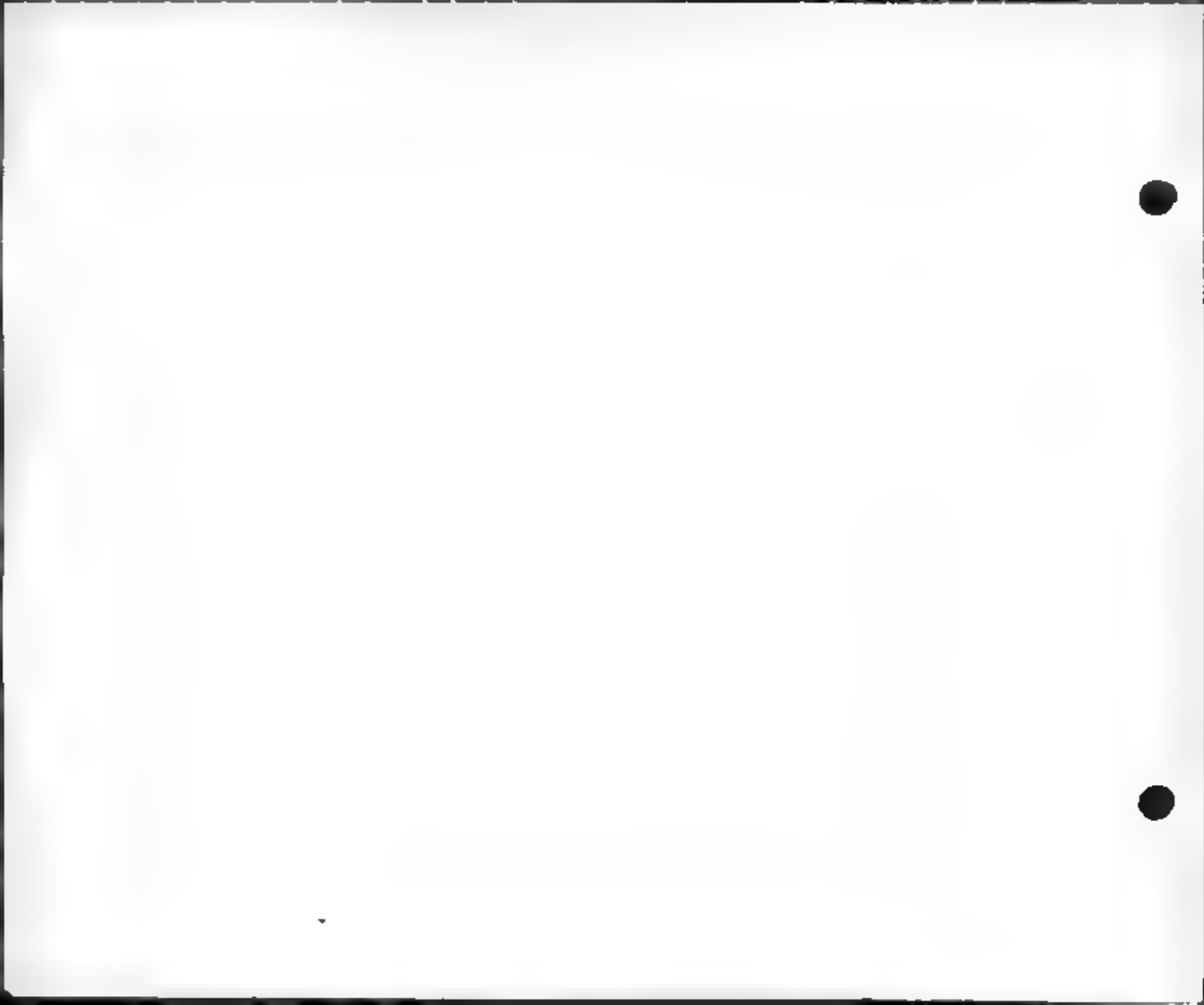
Item 18-1.5. 301 W. 1 + 3 MARYLAND AND STATE DEPARTMENT OF HEALTH
19 Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07138

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE Where deceased lived if institution Residence before admission a. STATE Maryland b. COUNTY Baltimore	
3 DECEASED a. NAME OF DECEASED Type of name James D. Kennedy b. SEX Male c. RACE OR COLOR White d. MARKS <input checked="" type="checkbox"/> NEVER MARKED <input type="checkbox"/> e. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4 DATE OF DEATH June 15, 1967 5 AGE 58 6 SEX Male 7 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 5 YEARS <input type="checkbox"/> 5 YEARS TO 10 YEARS <input type="checkbox"/> 10 YEARS TO 15 YEARS <input type="checkbox"/> 15 YEARS TO 20 YEARS <input type="checkbox"/> 20 YEARS TO 25 YEARS <input type="checkbox"/> 25 YEARS TO 30 YEARS <input type="checkbox"/> 30 YEARS TO 35 YEARS <input type="checkbox"/> 35 YEARS TO 40 YEARS <input type="checkbox"/> 40 YEARS TO 45 YEARS <input type="checkbox"/> 45 YEARS TO 50 YEARS <input type="checkbox"/> 50 YEARS TO 55 YEARS <input type="checkbox"/> 55 YEARS TO 60 YEARS <input type="checkbox"/> 60 YEARS TO 65 YEARS <input type="checkbox"/> 65 YEARS TO 70 YEARS <input type="checkbox"/> 70 YEARS TO 75 YEARS <input type="checkbox"/> 75 YEARS TO 80 YEARS <input type="checkbox"/> 80 YEARS TO 85 YEARS <input type="checkbox"/> 85 YEARS TO 90 YEARS <input type="checkbox"/> 90 YEARS TO 95 YEARS <input type="checkbox"/> 95 YEARS TO 100 YEARS <input type="checkbox"/> 100 YEARS TO 105 YEARS <input type="checkbox"/> 105 YEARS TO 110 YEARS <input type="checkbox"/> 110 YEARS TO 115 YEARS <input type="checkbox"/> 115 YEARS TO 120 YEARS <input type="checkbox"/> 120 YEARS TO 125 YEARS <input type="checkbox"/> 125 YEARS TO 130 YEARS <input type="checkbox"/> 130 YEARS TO 135 YEARS <input type="checkbox"/> 135 YEARS TO 140 YEARS <input type="checkbox"/> 140 YEARS TO 145 YEARS <input type="checkbox"/> 145 YEARS TO 150 YEARS <input type="checkbox"/> 150 YEARS TO 155 YEARS <input type="checkbox"/> 155 YEARS TO 160 YEARS <input type="checkbox"/> 160 YEARS TO 165 YEARS <input type="checkbox"/> 165 YEARS TO 170 YEARS <input type="checkbox"/> 170 YEARS TO 175 YEARS <input type="checkbox"/> 175 YEARS TO 180 YEARS <input type="checkbox"/> 180 YEARS TO 185 YEARS <input type="checkbox"/> 185 YEARS TO 190 YEARS <input type="checkbox"/> 190 YEARS TO 195 YEARS <input type="checkbox"/> 195 YEARS TO 200 YEARS <input type="checkbox"/> 200 YEARS TO 205 YEARS <input type="checkbox"/> 205 YEARS TO 210 YEARS <input type="checkbox"/> 210 YEARS TO 215 YEARS <input type="checkbox"/> 215 YEARS TO 220 YEARS <input type="checkbox"/> 220 YEARS TO 225 YEARS <input type="checkbox"/> 225 YEARS TO 230 YEARS <input type="checkbox"/> 230 YEARS TO 235 YEARS <input type="checkbox"/> 235 YEARS TO 240 YEARS <input type="checkbox"/> 240 YEARS TO 245 YEARS <input type="checkbox"/> 245 YEARS TO 250 YEARS <input type="checkbox"/> 250 YEARS TO 255 YEARS <input type="checkbox"/> 255 YEARS TO 260 YEARS <input type="checkbox"/> 260 YEARS TO 265 YEARS <input type="checkbox"/> 265 YEARS TO 270 YEARS <input type="checkbox"/> 270 YEARS TO 275 YEARS <input type="checkbox"/> 275 YEARS TO 280 YEARS <input type="checkbox"/> 280 YEARS TO 285 YEARS <input type="checkbox"/> 285 YEARS TO 290 YEARS <input type="checkbox"/> 290 YEARS TO 295 YEARS <input type="checkbox"/> 295 YEARS TO 300 YEARS <input type="checkbox"/> 300 YEARS TO 305 YEARS <input type="checkbox"/> 305 YEARS TO 310 YEARS <input type="checkbox"/> 310 YEARS TO 315 YEARS <input type="checkbox"/> 315 YEARS TO 320 YEARS <input type="checkbox"/> 320 YEARS TO 325 YEARS <input type="checkbox"/> 325 YEARS TO 330 YEARS <input type="checkbox"/> 330 YEARS TO 335 YEARS <input type="checkbox"/> 335 YEARS TO 340 YEARS <input type="checkbox"/> 340 YEARS TO 345 YEARS <input type="checkbox"/> 345 YEARS TO 350 YEARS <input type="checkbox"/> 350 YEARS TO 355 YEARS <input type="checkbox"/> 355 YEARS TO 360 YEARS <input type="checkbox"/> 360 YEARS TO 365 YEARS <input type="checkbox"/> 365 YEARS TO 370 YEARS <input type="checkbox"/> 370 YEARS TO 375 YEARS <input type="checkbox"/> 375 YEARS TO 380 YEARS <input type="checkbox"/> 380 YEARS TO 385 YEARS <input type="checkbox"/> 385 YEARS TO 390 YEARS <input type="checkbox"/> 390 YEARS TO 395 YEARS <input type="checkbox"/> 395 YEARS TO 400 YEARS <input type="checkbox"/> 400 YEARS TO 405 YEARS <input type="checkbox"/> 405 YEARS TO 410 YEARS <input type="checkbox"/> 410 YEARS TO 415 YEARS <input type="checkbox"/> 415 YEARS TO 420 YEARS <input type="checkbox"/> 420 YEARS TO 425 YEARS <input type="checkbox"/> 425 YEARS TO 430 YEARS <input type="checkbox"/> 430 YEARS TO 435 YEARS <input type="checkbox"/> 435 YEARS TO 440 YEARS <input type="checkbox"/> 440 YEARS TO 445 YEARS <input type="checkbox"/> 445 YEARS TO 450 YEARS <input type="checkbox"/> 450 YEARS TO 455 YEARS <input type="checkbox"/> 455 YEARS TO 460 YEARS <input type="checkbox"/> 460 YEARS TO 465 YEARS <input type="checkbox"/> 465 YEARS TO 470 YEARS <input type="checkbox"/> 470 YEARS TO 475 YEARS <input type="checkbox"/> 475 YEARS TO 480 YEARS <input type="checkbox"/> 480 YEARS TO 485 YEARS <input type="checkbox"/> 485 YEARS TO 490 YEARS <input type="checkbox"/> 490 YEARS TO 495 YEARS <input type="checkbox"/> 495 YEARS TO 500 YEARS <input type="checkbox"/> 500 YEARS TO 505 YEARS <input type="checkbox"/> 505 YEARS TO 510 YEARS <input type="checkbox"/> 510 YEARS TO 515 YEARS <input type="checkbox"/> 515 YEARS TO 520 YEARS <input type="checkbox"/> 520 YEARS TO 525 YEARS <input type="checkbox"/> 525 YEARS TO 530 YEARS <input type="checkbox"/> 530 YEARS TO 535 YEARS <input type="checkbox"/> 535 YEARS TO 540 YEARS <input type="checkbox"/> 540 YEARS TO 545 YEARS <input type="checkbox"/> 545 YEARS TO 550 YEARS <input type="checkbox"/> 550 YEARS TO 555 YEARS <input type="checkbox"/> 555 YEARS TO 560 YEARS <input type="checkbox"/> 560 YEARS TO 565 YEARS <input type="checkbox"/> 565 YEARS TO 570 YEARS <input type="checkbox"/> 570 YEARS TO 575 YEARS <input type="checkbox"/> 575 YEARS TO 580 YEARS <input type="checkbox"/> 580 YEARS TO 585 YEARS <input type="checkbox"/> 585 YEARS TO 590 YEARS <input type="checkbox"/> 590 YEARS TO 595 YEARS <input type="checkbox"/> 595 YEARS TO 600 YEARS <input type="checkbox"/> 600 YEARS TO 605 YEARS <input type="checkbox"/> 605 YEARS TO 610 YEARS <input type="checkbox"/> 610 YEARS TO 615 YEARS <input type="checkbox"/> 615 YEARS TO 620 YEARS <input type="checkbox"/> 620 YEARS TO 625 YEARS <input type="checkbox"/> 625 YEARS TO 630 YEARS <input type="checkbox"/> 630 YEARS TO 635 YEARS <input type="checkbox"/> 635 YEARS TO 640 YEARS <input type="checkbox"/> 640 YEARS TO 645 YEARS <input type="checkbox"/> 645 YEARS TO 650 YEARS <input type="checkbox"/> 650 YEARS TO 655 YEARS <input type="checkbox"/> 655 YEARS TO 660 YEARS <input type="checkbox"/> 660 YEARS TO 665 YEARS <input type="checkbox"/> 665 YEARS TO 670 YEARS <input type="checkbox"/> 670 YEARS TO 675 YEARS <input type="checkbox"/> 675 YEARS TO 680 YEARS <input type="checkbox"/> 680 YEARS TO 685 YEARS <input type="checkbox"/> 685 YEARS TO 690 YEARS <input type="checkbox"/> 690 YEARS TO 695 YEARS <input type="checkbox"/> 695 YEARS TO 700 YEARS <input type="checkbox"/> 700 YEARS TO 705 YEARS <input type="checkbox"/> 705 YEARS TO 710 YEARS <input type="checkbox"/> 710 YEARS TO 715 YEARS <input type="checkbox"/> 715 YEARS TO 720 YEARS <input type="checkbox"/> 720 YEARS TO 725 YEARS <input type="checkbox"/> 725 YEARS TO 730 YEARS <input type="checkbox"/> 730 YEARS TO 735 YEARS <input type="checkbox"/> 735 YEARS TO 740 YEARS <input type="checkbox"/> 740 YEARS TO 745 YEARS <input type="checkbox"/> 745 YEARS TO 750 YEARS <input type="checkbox"/> 750 YEARS TO 755 YEARS <input type="checkbox"/> 755 YEARS TO 760 YEARS <input type="checkbox"/> 760 YEARS TO 765 YEARS <input type="checkbox"/> 765 YEARS TO 770 YEARS <input type="checkbox"/> 770 YEARS TO 775 YEARS <input type="checkbox"/> 775 YEARS TO 780 YEARS <input type="checkbox"/> 780 YEARS TO 785 YEARS <input type="checkbox"/> 785 YEARS TO 790 YEARS <input type="checkbox"/> 790 YEARS TO 795 YEARS <input type="checkbox"/> 795 YEARS TO 800 YEARS <input type="checkbox"/> 800 YEARS TO 805 YEARS <input type="checkbox"/> 805 YEARS TO 810 YEARS <input type="checkbox"/> 810 YEARS TO 815 YEARS <input type="checkbox"/> 815 YEARS TO 820 YEARS <input type="checkbox"/> 820 YEARS TO 825 YEARS <input type="checkbox"/> 825 YEARS TO 830 YEARS <input type="checkbox"/> 830 YEARS TO 835 YEARS <input type="checkbox"/> 835 YEARS TO 840 YEARS <input type="checkbox"/> 840 YEARS TO 845 YEARS <input type="checkbox"/> 845 YEARS TO 850 YEARS <input type="checkbox"/> 850 YEARS TO 855 YEARS <input type="checkbox"/> 855 YEARS TO 860 YEARS <input type="checkbox"/> 860 YEARS TO 865 YEARS <input type="checkbox"/> 865 YEARS TO 870 YEARS <input type="checkbox"/> 870 YEARS TO 875 YEARS <input type="checkbox"/> 875 YEARS TO 880 YEARS <input type="checkbox"/> 880 YEARS TO 885 YEARS <input type="checkbox"/> 885 YEARS TO 890 YEARS <input type="checkbox"/> 890 YEARS TO 895 YEARS <input type="checkbox"/> 895 YEARS TO 900 YEARS <input type="checkbox"/> 900 YEARS TO 905 YEARS <input type="checkbox"/> 905 YEARS TO 910 YEARS <input type="checkbox"/> 910 YEARS TO 915 YEARS <input type="checkbox"/> 915 YEARS TO 920 YEARS <input type="checkbox"/> 920 YEARS TO 925 YEARS <input type="checkbox"/> 925 YEARS TO 930 YEARS <input type="checkbox"/> 930 YEARS TO 935 YEARS <input type="checkbox"/> 935 YEARS TO 940 YEARS <input type="checkbox"/> 940 YEARS TO 945 YEARS <input type="checkbox"/> 945 YEARS TO 950 YEARS <input type="checkbox"/> 950 YEARS TO 955 YEARS <input type="checkbox"/> 955 YEARS TO 960 YEARS <input type="checkbox"/> 960 YEARS TO 965 YEARS <input type="checkbox"/> 965 YEARS TO 970 YEARS <input type="checkbox"/> 970 YEARS TO 975 YEARS <input type="checkbox"/> 975 YEARS TO 980 YEARS <input type="checkbox"/> 980 YEARS TO 985 YEARS <input type="checkbox"/> 985 YEARS TO 990 YEARS <input type="checkbox"/> 990 YEARS TO 995 YEARS <input type="checkbox"/> 995 YEARS TO 1000 YEARS <input type="checkbox"/> 1000 YEARS TO 1005 YEARS <input type="checkbox"/> 1005 YEARS TO 1010 YEARS <input type="checkbox"/> 1010 YEARS TO 1015 YEARS <input type="checkbox"/> 1015 YEARS TO 1020 YEARS <input type="checkbox"/> 1020 YEARS TO 1025 YEARS <input type="checkbox"/> 1025 YEARS TO 1030 YEARS <input type="checkbox"/> 1030 YEARS TO 1035 YEARS <input type="checkbox"/> 1035 YEARS TO 1040 YEARS <input type="checkbox"/> 1040 YEARS TO 1045 YEARS <input type="checkbox"/> 1045 YEARS TO 1050 YEARS <input type="checkbox"/> 1050 YEARS TO 1055 YEARS <input type="checkbox"/> 1055 YEARS TO 1060 YEARS <input type="checkbox"/> 1060 YEARS TO 1065 YEARS <input type="checkbox"/> 1065 YEARS TO 1070 YEARS <input type="checkbox"/> 1070 YEARS TO 1075 YEARS <input type="checkbox"/> 1075 YEARS TO 1080 YEARS <input type="checkbox"/> 1080 YEARS TO 1085 YEARS <input type="checkbox"/> 1085 YEARS TO 1090 YEARS <input type="checkbox"/> 1090 YEARS TO 1095 YEARS <input type="checkbox"/> 1095 YEARS TO 1100 YEARS <input type="checkbox"/> 1100 YEARS TO 1105 YEARS <input type="checkbox"/> 1105 YEARS TO 1110 YEARS <input type="checkbox"/> 1110 YEARS TO 1115 YEARS <input type="checkbox"/> 1115 YEARS TO 1120 YEARS <input type="checkbox"/> 1120 YEARS TO 1125 YEARS <input type="checkbox"/> 1125 YEARS TO 1130 YEARS <input type="checkbox"/> 1130 YEARS TO 1135 YEARS <input type="checkbox"/> 1135 YEARS TO 1140 YEARS <input type="checkbox"/> 1140 YEARS TO 1145 YEARS <input type="checkbox"/> 1145 YEARS TO 1150 YEARS <input type="checkbox"/> 1150 YEARS TO 1155 YEARS <input type="checkbox"/> 1155 YEARS TO 1160 YEARS <input type="checkbox"/> 1160 YEARS TO 1165 YEARS <input type="checkbox"/> 1165 YEARS TO 1170 YEARS <input type="checkbox"/> 1170 YEARS TO 1175 YEARS <input type="checkbox"/> 1175 YEARS TO 1180 YEARS <input type="checkbox"/> 1180 YEARS TO 1185 YEARS <input type="checkbox"/> 1185 YEARS TO 1190 YEARS <input type="checkbox"/> 1190 YEARS TO 1195 YEARS <input type="checkbox"/> 1195 YEARS TO 1200 YEARS <input type="checkbox"/> 1200 YEARS TO 1205 YEARS <input type="checkbox"/> 1205 YEARS TO 1210 YEARS <input type="checkbox"/> 1210 YEARS TO 1215 YEARS <input type="checkbox"/> 1215 YEARS TO 1220 YEARS <input type="checkbox"/> 1220 YEARS TO 1225 YEARS <input type="checkbox"/> 1225 YEARS TO 1230 YEARS <input type="checkbox"/> 1230 YEARS TO 1235 YEARS <input type="checkbox"/> 1235 YEARS TO 1240 YEARS <input type="checkbox"/> 1240 YEARS TO 1245 YEARS <input type="checkbox"/> 1245 YEARS TO 1250 YEARS <input type="checkbox"/> 1250 YEARS TO 1255 YEARS <input type="checkbox"/> 1255 YEARS TO 1260 YEARS <input type="checkbox"/> 1260 YEARS TO 1265 YEARS <input type="checkbox"/> 1265 YEARS TO 1270 YEARS <input type="checkbox"/> 1270 YEARS TO 1275 YEARS <input type="checkbox"/> 1275 YEARS TO 1280 YEARS <input type="checkbox"/> 1280 YEARS TO 1285 YEARS <input type="checkbox"/> 1285 YEARS TO 1290 YEARS <input type="checkbox"/> 1290 YEARS TO 1295 YEARS <input type="checkbox"/> 1295 YEARS TO 1300 YEARS <input type="checkbox"/> 1300 YEARS TO 1305 YEARS <input type="checkbox"/> 1305 YEARS TO 1310 YEARS <input type="checkbox"/> 1310 YEARS TO 1315 YEARS <input type="checkbox"/> 1315 YEARS TO 1320 YEARS <input type="checkbox"/> 1320 YEARS TO 1325 YEARS <input type="checkbox"/> 1325 YEARS TO 1330 YEARS <input type="checkbox"/> 1330 YEARS TO 1335 YEARS <input type="checkbox"/> 1335 YEARS TO 1340 YEARS <input type="checkbox"/> 1340 YEARS TO 1345 YEARS <input type="checkbox"/> 1345 YEARS TO 1350 YEARS <input type="checkbox"/> 1350 YEARS TO 1355 YEARS <input type="checkbox"/> 1355 YEARS TO 1360 YEARS <input type="checkbox"/> 1360 YEARS TO 1365 YEARS <input type="checkbox"/> 1365 YEARS TO 1370 YEARS <input type="checkbox"/> 1370 YEARS TO 1375 YEARS <input type="checkbox"/> 1375 YEARS TO 1380 YEARS <input type="checkbox"/> 1380 YEARS TO 1385 YEARS <input type="checkbox"/> 1385 YEARS TO 1390 YEARS <input type="checkbox"/> 1390 YEARS TO 1395 YEARS <input type="checkbox"/> 1395 YEARS TO 1400 YEARS <input type="checkbox"/> 1400 YEARS TO 1405 YEARS <input type="checkbox"/> 1405 YEARS TO 1410 YEARS <input type="checkbox"/> 1410 YEARS TO 1415 YEARS <input type="checkbox"/> 1415 YEARS TO 1420 YEARS <input type="checkbox"/> 1420 YEARS TO 1425 YEARS <input type="checkbox"/> 1425 YEARS TO 1430 YEARS <input type="checkbox"/> 1430 YEARS TO 1435 YEARS <input type="checkbox"/> 1435 YEARS TO 1440 YEARS <input type="checkbox"/> 1440 YEARS TO 1445 YEARS <input type="checkbox"/> 1445 YEARS TO 1450 YEARS <input type="checkbox"/> 1450 YEARS TO 1455 YEARS <input type="checkbox"/> 1455 YEARS TO 1460 YEARS <input type="checkbox"/> 1460 YEARS TO 1465 YEARS <input type="checkbox"/> 1465 YEARS TO 1470 YEARS <input type="checkbox"/> 1470 YEARS TO 1475 YEARS <input type="checkbox"/> 1475 YEARS TO 1480 YEARS <input type="checkbox"/> 1480 YEARS TO 1485 YEARS <input type="checkbox"/> 1485 YEARS TO 1490 YEARS <input type="checkbox"/> 1490 YEARS TO 1495 YEARS <input type="checkbox"/> 1495 YEARS TO 1500 YEARS <input type="checkbox"/> 1500 YEARS TO 1505 YEARS <input type="checkbox"/> 1505 YEARS TO 1510 YEARS <input type="checkbox"/> 1510 YEARS TO 1515 YEARS <input type="checkbox"/> 1515 YEARS TO 1520 YEARS <input type="checkbox"/> 1520 YEARS TO 1525 YEARS <input type="checkbox"/> 1525 YEARS TO 1530 YEARS <input type="checkbox"/> 1530 YEARS TO 1535 YEARS <input type="checkbox"/> 1535 YEARS TO 1540 YEARS <input type="checkbox"/> 1540 YEARS TO 1545 YEARS <input type="checkbox"/> 1545 YEARS TO 1550 YEARS <input type="checkbox"/> 1550 YEARS TO 1555 YEARS <input type="checkbox"/> 1555 YEARS TO 1560 YEARS <input type="checkbox"/> 1560 YEARS TO 1565 YEARS <input type="checkbox"/> 1565 YEARS TO 1570 YEARS <input type="checkbox"/> 1570 YEARS TO 1575 YEARS <input type="checkbox"/> 1575 YEARS TO 1580 YEARS <input type="checkbox"/> 1580 YEARS TO 1585 YEARS <input type="checkbox"/> 1585 YEARS TO 1590 YEARS <input type="checkbox"/> 1590 YEARS TO 1595 YEARS <input type="checkbox"/> 1595 YEARS TO 1600 YEARS <input type="checkbox"/> 1600 YEARS TO 1605 YEARS <input type="checkbox"/> 1605 YEARS TO 1610 YEARS <input type="checkbox"/> 1610 YEARS TO 1615 YEARS <input type="checkbox"/> 1615 YEARS TO 1620 YEARS <input type="checkbox"/> 1620 YEARS TO 1625 YEARS <input type="checkbox"/> 1625 YEARS TO 1630 YEARS <input type="checkbox"/> 1630 YEARS TO 1635 YEARS <input type="checkbox"/> 1635 YEARS TO 1640 YEARS <input type="checkbox"/> 1640 YEARS TO 1645 YEARS <input type="checkbox"/> 1645 YEARS TO 1650 YEARS <input type="checkbox"/> 1650 YEARS TO 1655 YEARS <input type="checkbox"/> 1655 YEARS TO 1660 YEARS <input type="checkbox"/> 1660 YEARS TO 1665 YEARS <input type="checkbox"/> 1665 YEARS TO 1670 YEARS <input type="checkbox"/> 1670 YEARS TO 1675 YEARS <input type="checkbox"/> 1675 YEARS TO 1680 YEARS <input type="checkbox"/> 1680 YEARS TO 1685 YEARS <input type="checkbox"/> 1685 YEARS TO 1690 YEARS <input type="checkbox"/> 1690 YEARS TO 1695 YEARS <input type="checkbox"/> 1695 YEARS TO 1700 YEARS <input type="checkbox"/> 1700 YEARS TO 1705 YEARS <input type="checkbox"/> 1705 YEARS TO 1710 YEARS <input type="checkbox"/> 1710 YEARS TO 1715 YEARS <input type="checkbox"/> 1715 YEARS TO 1720 YEARS <input type="checkbox"/> 1720 YEARS TO 1725 YEARS <input type="checkbox"/> 1725 YEARS TO 1730 YEARS <input type="checkbox"/> 1730 YEARS TO 1735 YEARS <input type="checkbox"/> 1735 YEARS TO 1740 YEARS <input type="checkbox"/> 1740 YEARS TO 1745 YEARS <input type="checkbox"/> 1745 YEARS TO 1750 YEARS <input type="checkbox"/> 1750 YEARS TO 1755 YEARS <input type="checkbox"/> 1755 YEARS TO 1760 YEARS <input type="checkbox"/> 1760 YEARS TO 1765 YEARS <input type="checkbox"/> 1765 YEARS TO 1770 YEARS <input type="checkbox"/> 1770 YEARS TO 1775 YEARS <input type="checkbox"/> 1775 YEARS TO 1780 YEARS <input type="checkbox"/> 1780 YEARS TO 1785 YEARS <input type="checkbox"/> 1785 YEARS TO 1790 YEARS <input type="checkbox"/> 1790 YEARS TO 1795 YEARS <input type="checkbox"/> 1795 YEARS TO 1800 YEARS <input type="checkbox"/> 1800 YEARS TO 1805 YEARS <input type="checkbox"/> 1805 YEARS TO 1810 YEARS <input type="checkbox"/> 1810 YEARS TO 1815 YEARS <input type="checkbox"/> 1815 YEARS TO 1820 YEARS <input type="checkbox"/> 1820 YEARS TO 1825 YEARS <input type="checkbox"/> 1825 YEARS TO 1830 YEARS <input type="checkbox"/> 1830 YEARS TO 1835 YEARS <input type="checkbox"/> 1835 YEARS TO 1840 YEARS <input type="checkbox"/> 1840 YEARS TO 1845 YEARS <input type="checkbox"/> 1845 YEARS TO 1850 YEARS <input type="checkbox"/> 1850 YEARS TO 1855 YEARS <input type="checkbox"/> 1855 YEARS TO 1860 YEARS <input type="checkbox"/> 1860 YEARS TO 1865 YEARS <input type="checkbox"/> 1865 YEARS TO 1870 YEARS <input type="checkbox"/> 1870 YEARS TO 1875 YEARS <input type="checkbox"/> 1875 YEARS TO 1880 YEARS <input type="checkbox"/> 1880 YEARS TO 1885 YEARS <input type="checkbox"/> 1885 YEARS TO 1890 YEARS <input type="checkbox"/> 1890 YEARS TO 1895 YEARS <input type="checkbox"/> 1895 YEARS TO 1900 YEARS <input type="checkbox"/> 1900 YEARS TO 1905 YEARS <input type="checkbox"/> 1905 YEARS TO 1910 YEARS <input type="checkbox"/> 1910 YEARS TO 1915 YEARS <input type="checkbox"/> 1915 YEARS TO 1920 YEARS <input type="checkbox"/> 1920 YEARS TO 1925 YEARS <input type="checkbox"/> 1925 YEARS TO 1930 YEARS <input type="checkbox"/> 1930 YEARS TO 1935 YEARS <input type="checkbox"/> 1935 YEARS TO 1940 YEARS <input type="checkbox"/> 1940 YEARS TO 1945 YEARS <input type="checkbox"/> 1945 YEARS TO 1950 YEARS <input type="checkbox"/> 1950 YEARS TO 1955 YEARS <input type="checkbox"/> 1955 YEARS TO 1960 YEARS <input type="checkbox"/> 1960 YEARS TO 1965 YEARS <input type="checkbox"/> 1965 YEARS TO 1970 YEARS <input type="checkbox"/> 1970 YEARS TO 1975 YEARS <input type="checkbox"/> 1975 YEARS TO 1980 YEARS <input type="checkbox"/> 1980 YEARS TO 1985 YEARS <input type="checkbox"/> 1985 YEARS TO 1990 YEARS <input type="checkbox"/> 1990 YEARS TO 1995 YEARS <input type="checkbox"/> 1995 YEARS TO 2000 YEARS <input type="checkbox"/> 2000 YEARS TO 2005 YEARS <input type="checkbox"/> 2005 YEARS TO 2010 YEARS <input type="checkbox"/> 2010 YEARS TO 2015 YEARS <input type="checkbox"/> 2015 YEARS TO 2020 YEARS <input type="checkbox"/> 2020 YEARS TO 2025 YEARS <input type="checkbox"/> 2025 YEARS TO 2030 YEARS <input type="checkbox"/> 2030 YEARS TO 2035 YEARS <input type="checkbox"/> 2035 YEARS TO 2040 YEARS <input type="checkbox"/> 2040 YEARS TO 2045 YEARS <input type="checkbox"/> 2045 YEARS TO 2050 YEARS <input type="checkbox"/> 2050 YEARS TO 2055 YEARS <input type="checkbox"/> 2055 YEARS TO 2060 YEARS <input type="checkbox"/> 2060 YEARS TO 2065 YEARS <input type="checkbox"/> 2065 YEARS TO 2070 YEARS <input type="checkbox"/> 2070 YEARS TO 2075 YEARS <input type="checkbox"/> 2075 YEARS TO 2080 YEARS <input type="checkbox"/> 2080 YEARS TO 2085 YEARS <input type="checkbox"/> 2085 YEARS TO 2090 YEARS <input type="checkbox"/> 2090 YEARS TO 2095 YEARS <input type="checkbox"/> 2095 YEARS TO 2100 YEARS <input type="checkbox"/> 2100 YEARS TO 2105 YEARS <input type="checkbox"/> 2105 YEARS TO 2110 YEARS <input type="checkbox"/> 2110 YEARS TO 2115 YEARS <input type="checkbox"/> 2115 YEARS TO 2120 YEARS <input type="checkbox"/> 2120 YEARS TO 2125 YEARS <input type="checkbox"/> 2125 YEARS TO 2130 YEARS <input type="checkbox"/> 2130 YEARS TO 2135 YEARS <input type="checkbox"/> 2135 YEARS TO 2140 YEARS <input type="checkbox"/> 2140 YEARS TO 2145 YEARS <input type="checkbox"/> 2145 YEARS TO 2150 YEARS <input type="checkbox"/> 2150 YEARS TO 2155 YEARS <input type="checkbox"/> 2155 YEARS TO 2160 YEARS <input type="checkbox"/> 2160 YEARS TO 2165 YEARS <input type="checkbox"/> 2165 YEARS TO 2170 YEARS <input type="checkbox"/> 2170 YEARS TO 2175 YEARS <input type="checkbox"/> 2175 YEARS TO 2180 YEARS <input type="checkbox"/> 2180 YEARS TO 2185 YEARS <input type="checkbox"/> 2185 YEARS TO 2190 YEARS <input type="checkbox"/> 2190 YEARS TO 2195 YEARS <input type="checkbox"/> 2195 YEARS TO 2200 YEARS <input type="checkbox"/> 2200 YEARS TO 2205 YEARS <input type="checkbox"/> 2205 YEARS TO 2210 YEARS <input type="checkbox"/> 2210 YEARS TO 2215 YEARS <input type="checkbox"/> 2215 YEARS TO 2220 YEARS <input type="checkbox"/> 2220 YEARS TO 2225 YEARS <input type="checkbox"/> 2225 YEARS TO 2230 YEARS <input type="checkbox"/> 2230 YEARS TO 2235 YEARS <input type="checkbox"/> 2235 YEARS TO 2240 YEARS <input type="checkbox"/> 2240 YEARS TO 2245 YEARS <input type="checkbox"/> 2245 YEARS TO 2250 YEARS <input type="checkbox"/> 2250 YEARS TO 2255 YEARS <input type="checkbox"/> 2255 YEARS TO 2260 YEARS <input type="checkbox"/> 2260 YEARS TO 2265 YEARS <input type="checkbox"/> 2265 YEARS TO 2270 YEARS <input type="checkbox"/> 2270 YEARS TO 2275 YEARS <input type="checkbox"/> 2275 YEARS TO 2280 YEARS <input type="checkbox"/> 2280 YEARS TO 2285 YEARS <input type="checkbox"/> 2285 YEARS TO 2290 YEARS <input type="checkbox"/> 2290 YEARS TO 2295 YEARS <input type="checkbox"/> 2295 YEARS TO 2300 YEARS <input type="checkbox"/> 2300 YEARS TO 2305 YEARS <input type="checkbox"/> 2305 YEARS TO 2310 YEARS <input type="checkbox"/> 2310 YEARS TO 2315 YEARS <input type="checkbox"/> 2315 YEARS TO 2320 YEARS <input type="checkbox"/> 2320 YEARS TO 2325 YEARS <input type="checkbox"/> 2325 YEARS TO 2330 YEARS <input type="checkbox"/> 2330 YEARS TO 2335 YEARS <input type="checkbox"/> 2335 YEARS TO 2340 YEARS <input type="checkbox"/> 2340 YEARS TO 2345 YEARS <input type="checkbox"/> 2345 YEARS TO 2350 YEARS <input type="checkbox"/> 2350 YEARS TO 2355 YEARS <input type="checkbox"/> 2355 YEARS TO 2360 YEARS <input type="checkbox"/> 2360 YEARS TO 2365 YEARS <input type="checkbox"/> 2365 YEARS TO 2370 YEARS <input type="checkbox"/> 2370 YEARS TO 2375 YEARS <input type="checkbox"/> 2375 YEARS TO 2380 YEARS <input type="checkbox"/> 2380 YEARS TO 2385 YEARS <input type="checkbox"/> 2385 YEARS TO 2390 YEARS <input type="checkbox"/> 2390 YEARS TO 2395 YEARS <input type="checkbox"/> 2395 YEARS TO 2400 YEARS <input type="checkbox"/> 2400 YEARS TO 2405 YEARS <input type="checkbox"/> 2405 YEARS TO 2410 YEARS <input type="checkbox"/> 2410 YEARS TO 2415 YEARS <input type="checkbox"/> 2415 YEARS TO 2420 YEARS <input type="checkbox"/> 2420 YEARS TO 2425 YEARS <input type="checkbox"/> 2425 YEARS TO 2430 YEARS <input type="checkbox"/> 2430 YEARS TO 2435 YEARS <input type="checkbox"/> 2435 YEARS TO 2440 YEARS <input type="checkbox"/> 2440 YEARS TO 2445 YEARS <input type="checkbox"/> 2445 YEARS TO 2450 YEARS <input type="checkbox"/> 2450 YEARS TO 2455 YEARS <input type="checkbox"/> 2455 YEARS TO 2460 YEARS <input type="checkbox"/> 2460 YEARS TO 2465 YEARS <input type="checkbox"/> 2465 YEARS TO 2470 YEARS <input type="checkbox"/> 2470 YEARS TO 2475 YEARS <input type="checkbox"/> 2475 YEARS TO 2480 YEARS <input type="checkbox"/> 2480 YEARS TO 2485 YEARS <input type="checkbox"/> 2485 YEARS TO 2490 YEARS <input type="checkbox"/> 2490 YEARS TO 2495 YEARS <input type="checkbox"/> 2495 YEARS TO 2500 YEARS <input type="checkbox"/> 2500 YEARS TO 2505 YEARS <input type="checkbox"/> 2505 YEARS TO 2510 YEARS <input type="checkbox"/> 2510 YEARS TO 2515 YEARS <input type="checkbox"/> 2515 YEARS TO 2520 YEARS <input type="checkbox"/> 2520 YEARS TO 2525 YEARS <input type="checkbox"/> 2525 YEARS TO 2530 YEARS <input type="checkbox"/> 2530 YEARS TO 2535 YEARS <input type="checkbox"/> 2535 YEARS TO 2540 YEARS <input type="checkbox"/> 2540 YEARS TO 2545 YEARS <input type="checkbox"/> 2545 YEARS TO 2550 YEARS <input type="checkbox"/> 2550 YEARS TO 2555 YEARS <input type="checkbox"/> 2555 YEARS TO 2560 YEARS <input type="checkbox"/> 2560 YEARS TO 2565 YEARS <input type="checkbox"/> 2565 YEARS TO 2570 YEARS <input type="checkbox"/> 2570 YEARS TO 2575 YEARS <input type="checkbox"/> 2575 YEARS TO 2580 YEARS <input type="checkbox"/> 2580 YEARS TO 2585 YEARS <input type="checkbox"/> 2585 YEARS TO 2590 YEARS <input type="checkbox"/> 2590 YEARS TO 2595 YEARS <input type="checkbox"/> 2595 YEARS TO 2600 YEARS <input type="checkbox"/> 2600 YEARS TO 2605 YEARS <input type="checkbox"/> 2605 YEARS TO 2610 YEARS <input type="checkbox"/> 2610 YEARS TO 2615 YEARS <input type="checkbox"/> 2615 YEARS TO 2620 YEARS <input type="checkbox"/> 2620 YEARS TO 2625 YEARS <input type="checkbox"/> 2625 YEARS TO 2630 YEARS <input type="checkbox"/> 2630 YEARS TO 2635 YEARS <input type="checkbox"/> 2635 YEARS TO 2640 YEARS <input type="checkbox"/> 2640 YEARS TO 2645 YEARS <input type="checkbox"/> 2645 YEARS TO 2650 YEARS <input type="checkbox"/> 2650 YEARS TO 2655 YEARS <input type="checkbox"/> 2655 YEARS TO 2660 YEARS <input type="checkbox"/> 2660 YEARS TO 2665 YEARS <input type="checkbox"/> 2665 YEARS TO 2670 YEARS <input type="checkbox"/> 2670 YEARS TO 2675 YEARS <input type="checkbox"/> 2675 YEARS TO 2680 YEARS <input type="checkbox"/> 2680 YEARS TO 2685 YEARS <input type="checkbox"/> 2685 YEARS TO 2690 YEARS <input type="checkbox"/> 2690 YEARS TO 2695 YEARS <input type="checkbox"/> 2695 YEARS TO 2700 YEARS <input type="checkbox"/> 2700 YEARS TO 2705 YEARS <input type="checkbox"/> 2705 YEARS TO 2710 YEARS <input type="checkbox"/> 2710 YEARS TO 2715 YEARS <input type="checkbox"/> 2715 YEARS TO 2720 YEARS <input type="checkbox"/> 2720 YEARS TO 2725 YEARS <input type="checkbox"/> 2725 YEARS TO 2730 YEARS <input type="checkbox"/> 2730 YEARS TO 2735 YEARS <input type="checkbox"/> 2735 YEARS TO 2740 YEARS <input type="checkbox"/> 2740 YEARS TO 2745 YEARS <input type="checkbox"/> 2745 YEARS TO 2750 YEARS <input type="checkbox"/> 2750 YEARS TO 2755 YEARS <input type="checkbox"/> 2755 YEARS TO 2760 YEARS <input type="checkbox"/> 2760 YEARS TO 2765 YEARS <input type="checkbox"/> 2765 YEARS TO 2770 YEARS <input type="checkbox"/> 2770 YEARS TO 2775 YEARS <input type="checkbox"/> 2775 YEARS TO 2780 YEARS <input type="checkbox"/> 2780 YEARS TO 2785 YEARS <input type="checkbox"/> 2785 YEARS TO 2790 YEARS <input type="checkbox"/> 2790 YEARS TO 2795 YEARS <input type="checkbox"/> 2795 YEARS TO 2800 YEARS <input type="checkbox"/> 2800 YEARS TO 2805 YEARS <input type="checkbox"/> 2805 YEARS TO 2810 YEARS <input type="checkbox"/> 2810 YEARS TO 2815 YEARS <input type="checkbox"/> 2815 YEARS TO 2820 YEARS <input type="checkbox"/> 2820 YEARS TO 2825 YEARS <input type="checkbox"/> 2825 YEARS TO 2830 YEARS <input type="checkbox"/> 2830 YEARS TO 2835 YEARS <input type="checkbox"/> 2835 YEARS TO 2840 YEARS <input type="checkbox"/> 2840 YEARS TO 2845 YEARS <input type="checkbox"/> 2845 YEARS TO 2850 YEARS <input type="checkbox"/> 2850 YEARS TO 2855 YEARS <input type="checkbox"/> 2855 YEARS TO 2860 YEARS <input type="checkbox"/> 2860 YEARS TO 2865 YEARS <input type="checkbox"/> 2865 YEARS TO 2870 YEARS <input type="checkbox"/> 2870 YEARS TO 2875 YEARS <input type="checkbox"/> 2875 YEARS TO 2880 YEARS <input type="checkbox"/> 2880 YEARS TO 2885 YEARS <input type="checkbox"/> 2885 YEARS TO 2890 YEARS <input type="checkbox"/> 2890 YEARS TO 2895 YEARS <input type="checkbox"/> 2895 YEARS TO 2900 YEARS <input type="checkbox"/> 2900 YEARS TO 2905 YEARS <input type="checkbox"/> 2905 YEARS TO 2910 YEARS <input type="checkbox"/> 2910 YEARS TO 2915 YEARS <input type="checkbox"/> 2915 YEARS TO 2920 YEARS <input type="checkbox"/> 2920 YEARS TO 2925 YEARS <input type="checkbox"/> 2925 YEARS TO 2930 YEARS <input type="checkbox"/> 2930 YEARS TO 2935 YEARS <input type="checkbox"/> 2935 YEARS TO 2940 YEARS <input type="checkbox"/> 2940 YEARS TO 2945 YEARS <input type="checkbox"/> 2945 YEARS TO 2950 YEARS <input type="checkbox"/> 2950 YEARS TO 2955 YEARS <input type="checkbox"/> 2955 YEARS TO 2960 YEARS <input type="checkbox"/> 2960 YEARS TO 2965 YEARS <input type="checkbox"/> 2965 YEARS TO 2970 YEARS <input type="checkbox"/> 2970 YEARS TO 2975 YEARS <input type="checkbox"/> 2975 YEARS TO 2980 YEARS <input type="checkbox"/> 2980 YEARS TO 2985 YEARS <input type="checkbox"/> 2985 YEARS TO 2990 YEARS <input type="checkbox"/> 2990 YEARS TO 2995 YEARS <input type="checkbox"/> 2995 YEARS TO 3000 YEARS <input type="checkbox"/> 3000 YEARS TO 3005 YEARS <input type="checkbox"/> 3005 YEARS TO 3010 YEARS <input type="checkbox"/> 3010 YEARS TO 3015 YEARS <input type="checkbox"/> 3015 YEARS TO 3020 YEARS <input type="checkbox"/> 3020 YEARS TO 3025 YEARS <input type="checkbox"/> 3025 YEARS TO 3030 YEARS <input type="checkbox"/> 3030 YEARS TO 3035 YEARS <input type="checkbox"/> 3035 YEARS TO 3040 YEARS <input type="checkbox"/> 3040 YEARS TO 3045 YEARS <input type="checkbox"/> 3045 YEARS TO 3050 YEARS <input type="checkbox"/> 3050 YEARS TO 3055 YEARS <input type="checkbox"/> 3055 YEARS TO 3060 YEARS <input type="checkbox"/> 3060 YEARS TO 3065 YEARS <input type="checkbox"/> 3065 YEARS TO 3070 YEARS <input type="checkbox"/> 3070 YEARS TO 3075 YEARS <input type="checkbox"/> 3075 YEARS TO 3080 YEARS <input type="checkbox"/> 3080 YEARS TO 3085 YEARS <input type="checkbox"/> 3085 YEARS TO 3090 YEARS <input type="checkbox"/> 3090 YEARS TO 3095 YEARS <input type="checkbox"/> 3095 YEARS TO 3100 YEARS <input type="checkbox"/> 3100 YEARS TO 3105 YEARS <input type="checkbox"/> 3105 YEARS TO 3110 YEARS <input type="checkbox"/> 3110 YEARS TO 3115 YEARS <input type="checkbox"/> 3115 YEARS TO 3120 YEARS <input type="checkbox"/> 3120 YEARS TO 3125 YEARS <input type="checkbox"/> 3125 YEARS TO 3130 YEARS <input type="checkbox"/> 3130 YEARS TO 3135 YEARS <input type="checkbox"/> 3135 YEARS TO 3140 YEARS <input type="checkbox"/> 3140 YEARS TO 3145 YEARS <input type="checkbox"/> 3145 YEARS TO 3150 YEARS <input type="checkbox"/> 3150 YEARS TO 3155 YEARS <input type="checkbox"/> 3155 YEARS TO 3160 YEARS <input type="checkbox"/> 3160 YEARS TO 3165 YEARS	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that he death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. If he attending physician and completed in by the funeral director. After this certificate has been signed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07807

07:39

PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE Where deceased lived, if institution. Residence before admission

a. STATE Maryland

b. COUNTY

~~MARYLAND~~

b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town

Catonsville

c. LENGTH OF STAY IN ID

1 Year

c. CITY OR TOWN if outside corporate limits

Baltimore

d. RACE and give nearest town

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)

Shady Nook Nursing Home

4. STREET ADDRESS

20 N. Beechfield Ave.

3. NAME OF DECEASED
Type as printed

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Anne

Rouse

Kent

June

23

19

67

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (in years last birthday)

10. UNDER Year

11. INDEFINITE

Female

White

WIDOWED ☒ DIVORCED ☐

March 15, 1890

77

12a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

xx

13. PLACE OF BIRTH

Plainsville, Kansas

14. COUNTRY OF WHAT COUNTRY?

USA

15. FATHER'S NAME

Ruben Rouse

16. MOTHER'S NAME

Rose Gooden

17. WA. DECEASED FATHER IN U.S. ARMY OR NAVY
Yes ☐ No ☐ If yes, give branch of service

18. SOCIAL SECURITY NO

INFORMANT

Address

336-07-0624D Gregory Kent, Reading, Penna.

19. CAUSE OF DEATH (Enter only one cause per line, in order of importance)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE

DUE TO

Conditions if any which gave rise to immediate cause

16. Interfering the underlying cause

DUE TO

PART II DEATH AT ONCE CAUSE CONDITION

CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN ONSET AND DEATH

Generalized Arteriosclerosis
Chronic Bronch Syndrome
Decubiti Multiple

3 yrs.
3 yrs
2 months

MEDICAL CERTIFICATE

20a. ACCIDENT OR UNDERLYING CAUSE
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 8)

21a. TIME OF INJURY Month, Day, Year
Hour, a.m., p.m.

21b. INJURY OF BODY
White ☐ Not White ☐
at work ☐ at work ☐

22a. PLACE OF INJURY Home, farm, factory, street, office, etc.

22b. CITY or town

County

State

23. I certify that this hospital attended he deceased from saw he deceased alive on

24. SIGNATURE

and that death occurred from the causes and on the date stated above

25. PHYSICIAN'S NAME (Type)

26. ATTENDING PHYSICIAN

27. MEDICAL DIRECTOR

28. STAFF PHYSICIAN

29. ADDRESS

1303 Frederick Rd

23a. BURIAL REMOVAL DATE THEREOF

Burial

June 26

23b. NAME OF CEMETERY OR CREMATORIUM

St. Johns Churchyard

23c. LOCATION City, town or county

Roch Hall, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Edgar L. Kane

ADDRESS

Church Hill, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JUN 27 1967

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07808

CERTIFICATE OF DEATH

67730

1 PLACE OF DEATH a COUNTY Baltimore, b CITY OR TOWN Baltimore c STATE MARYLAND		2 USUAL RESIDENCE "Where deceased lived if in different Residence before admission." a STATE Maryland b COUNTY c CITY OR TOWN Baltimore d ZIP CODE 21236	
3 NAME OF DECEASED Type in print Sophia Florence Kerzog		4 DATE OF DEATH Month June Day 2 Year 1967	
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-25-14
9 AGE in years last birthday 53		10 IF UNDER 1 YEAR Month 53 Day 53 Hour 53 Min 53	
11a USUAL OCCUPATION Give kind of work done during life (working life when retired) housewife		11b KIND OF BUSINESS OR INDUSTRY Home	
12 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		13 WHEN & WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME Ignacy Majka		15 MOTHER'S MAIDEN NAME Wozalia Marzalek	
16 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes no, or unknown) (If yes give year or dates of service) no		17 SOCIAL SECURITY NO no	
18 INFORMANT Mr Michael Kerzog 9110 Deborah Avenue		19 ADDRESS Adie	
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). a. IMMEDIATE CAUSE Adenocarcinoma - ovary with generalized metastasis b. Condition if any which gave rise to immediate cause c. stating the underlying cause 1104 DUE TO metastasis		21 INTERVAL BETWEEN ONSET AND DEATH	
22 PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 20			
23a MEDICAL HISTORY a. PREVIOUS ILLNESSES b. SURGICAL HISTORY c. TRAUMA d. ALLERGIC REACTIONS e. OTHER		23b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 or item B.)	
24 TIME OF INJURY Month Day Year Hour am p.m.		25 INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
26 PLACE OF INJURY Home, farm, factory, street, office, bldg., etc.		27 CITY or town (County) (State)	
28 I certify that (1) (this hospital) attended the deceased from May 28 19 67 to June 2 19 67 that, (2) I have last saw the deceased alive on June 2 19 67 and that death occurred at 9:40 PM from causes and on the date stated above			
29a SIGNATURE Glocrito Sagisi		29b DATE SIGNED June 2, 1967	
30 PHYSICIAN'S NAME (Type)		31 ADDRESS 7620 York Rd. Baltimore, Md. 21204	
32a BURIAL, CREMATION, REMOVAL (Specify)	32b DATE THEREOF	32c NAME OF CEMETERY OR CREMATORY	32d LOCATION (City or town) (County) (State)
Burial	6-6-1967	St. Stanislaus Cemetery	Baltimore, Md.
33 FUNERAL DIRECTOR ADDRESS		34 REGD BY REGISTRAR	
		DATE JUN 6 1967	
35 REGISTRAR'S SIGNATURE James Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, for page 3 should be detached for use as the burial-transit permit. Then please remove a bon paper. Pages and 2 should be filed with the State Dept of Health. Page 4 should be filed with the State Dept of Health. Page 4 should be filed with the State Dept of Health.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The physician or attending physician may be retained by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 and attach them to the certificate. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07803

Item #2d File #3, 2, 0, 6, 2

07731

1 PLACE OF DEATH

a. CITY OR TOWN (If outside corporate limits write R. for Rural and give name of town)

b. CITY OR TOWN (If outside corporate limits write R. for Rural and give name of town)

c. LENGTH OF STAY IN R. (If outside corporate limits write R. for Rural and give name of town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

e. NAME OF DECEASED (Type of death)

f. SEX

g. TO OR OR RACE

h. MARRIED ☐ NEVER MARRIED ☐

i. WIDOWED ☒ DIVORCED ☐

j. DATE OF BIRTH

k. AGE (In years last birthday)

l. UNDER 1 YEAR

m. UNDER 24 HRS

n. MONTHS

o. DAYS

p. HOURS

q. MINUTES

r. USUAL OCCUPATION (Give kind of work done during most of working life, etc.)

s. KIND OF BUSINESS OR IND. STRY

t. BIRTHPLACE (Country & state or foreign country)

u. CITIZEN OF WHAT COUNTRY?

v. A1-TER'S NAME

w. MOTHER MAIDEN NAME

x. WAS DECEASED EVER IN U.S. ARMED FORCES?

y. SOLICITATION NO.

z. INFORMANT

aa. CAUSE OF DEATH (Enter only one cause per line a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z)

ab. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

ac. DUE TO

ad. Conditions if any which gave rise to immediate cause

ae. stating the underlying cause last

af. PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (ONLINE GIVEN IN PART I)

ag. ACCIDENT W/IN FLYING

ah. IN FLYING

ai. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II on page 2 of form)

aj. TIME OF INJURY (Month Day Year)

ak. INJURY OCCURRED (While at work ☐ Not while at work ☐

al. PLACE OF INJURY (Home farm factory street office bldg. etc.)

am. CITY OR TOWN

an. COUNTY

ao. STATE

ap. I certify that the hospital attended the deceased from June 18 1967 to June 19 1967 that (1) was last saw the deceased alive on June 18 1967 and that death occurred at 3:30 PM from the causes and on the date listed above

aq. A TENDING PHYSICIAN (PHYSICIAN) (MEDICAL DIRECTOR) (STAFF PHYSICIAN) (DATE) (SIGNED)

ar. NAME (Type) (G M BAUMGARDNER) (BALTIMORE 21206)

as. BURIAL CREMATION (REMOVAL) (DATE THEREOF) (NAME OF CEMETERY OR CREMATORY) (LOCATION (City town or county) (State)

at. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) (REC'D BY REGISTRAR) (REGISTRAR'S SIGNATURE) (DATE) (JUN 22 1967) (JUDGE)

Crownary occlusion
Arteriosclerotic cardiac vascular disease 5 yrs
Sudden

June 18 1967 to June 19 1967 that (1) was last saw the deceased alive on June 18 1967 and that death occurred at 3:30 PM from the causes and on the date listed above
A TENDING PHYSICIAN (PHYSICIAN) (MEDICAL DIRECTOR) (STAFF PHYSICIAN) (DATE) (SIGNED)
G M BAUMGARDNER BALTIMORE 21206
BURIAL CREMATION (REMOVAL) (DATE THEREOF) (NAME OF CEMETERY OR CREMATORY) (LOCATION (City town or county) (State)
FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) (REC'D BY REGISTRAR) (REGISTRAR'S SIGNATURE) (DATE) (JUN 22 1967) (JUDGE)



YR A 5 4
25th 1 62

750 40 TRAF ST-HAM RE
Charles Judge



07811

CERTIFICATE OF DEATH

77-33

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE (Where deceased lived if in Maryland. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>801 - COUGH C.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
NAME OF DECEASED Type or print <u>Morris</u>		Middle <u>KISHTER</u>	4 DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1967</u>
a. SEX <u>Male</u>	b. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5 DATE OF BIRTH <u>11-15-90</u>
6 AGE in year as birthday <u>76</u>		7 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hour <u>0</u> Min <u>0</u>	
8a. INDUSTRY (Give kind of work done during most of working life, even if retired) <u>Retired</u>		8b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
9 BIRTHPLACE (County & State or foreign country) <u>ENGLAND</u>		10 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11 FATHER'S NAME <u>ABRAHAM</u>		12 MOTHER'S M maiden name <u>KATE</u>	
13 a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <u>No</u>		13 b. SOCIAL SECURITY NO. <u>3-21-1714</u>	
14 INFORMANT <u>Mrs Lena KISHTER</u>		Address <u>Same</u>	
15 CAUSE OF DEATH (Enter only one cause on line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost <u>Hodgkins Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I <u>Interval between onset and death</u>			
16 a. IDENTIFY WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (1) EITHER NOTIFY MEDICAL EXAMINER		16 b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 16c)	
17 a. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		17 b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
17 c. PLACE OF INJURY Home farm, factory, street, office bldg., etc.		17 d. (City or town) (County) (State)	
18 I certify that this hospital attended the deceased from <u>Jan 19 1967</u> to <u>6/23 1967</u> that we last saw the deceased alive on <u>6/23 1967</u> and that death occurred at <u>11</u> M from causes and on the date stated above			
20a SIGNATURE <u>K. Prince Friedman</u>		20b DATE SIGNED <u>6/23/67</u>	
21 PHYSICIAN'S NAME Type		22 ADDRESS <u>26 Kean St. Baltimore</u>	
23a BURIAL CREMATION REMOVAL Specify: <u>Burial</u>		23b DATE THEREOF <u>6/25/1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Bel Air Young Men</u>		23d LOCATION (City or town) (County) (State) <u>Baltimore Md</u>	
24 FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son</u>		25a RECEIVED BY REGISTRAR DATE <u>JUN 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>W. J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and return them to the State Dept. of Health prior to burial, cremation or removal, and notify the funeral director that the certificate has been filed with the State Dept. of Health.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please acquire carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07812 07801

1. PLACE OF DEATH
a. COUNTY BA. MORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND
c. LENGTH OF STAY IN 2 WK.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7711 HILLCROFT RD

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD.
b. COUNTY BA. MORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1. BAL. BAL. MORE
d. STREET ADDRESS 7711 HILLCROFT RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First EARL Middle PIPER Last KNIGHT

4. DATE OF DEATH
Month JUNE Day 3 Year 1967

5. SEX M 6. COLOR OR RACE N 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH NOV. 17, 1914 9. AGE (In year's last birthday) 52 yrs. 10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER 10b. KIND OF BUSINESS OR INDUSTRY MANAGER 11. BIRTHPLACE (County & State, or foreign country) BAL. MD 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME MARION C. KNIGHT 14. MOTHER'S MAIDEN NAME ELIZABETH HANNA PIPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown, if yes give war or dates of service NO 16. SOCIAL SECURITY NO. XXXXXXXXXX 17. INFORMANT Herbert N. Knight same Address XXXXXXXXXX

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4511 ACUTE MYOCARDIAL INFARCTION
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b). ART. RHEUMATISM VASCULAR DISEASE
(c). ART. RHEUMATISM VASCULAR DISEASE

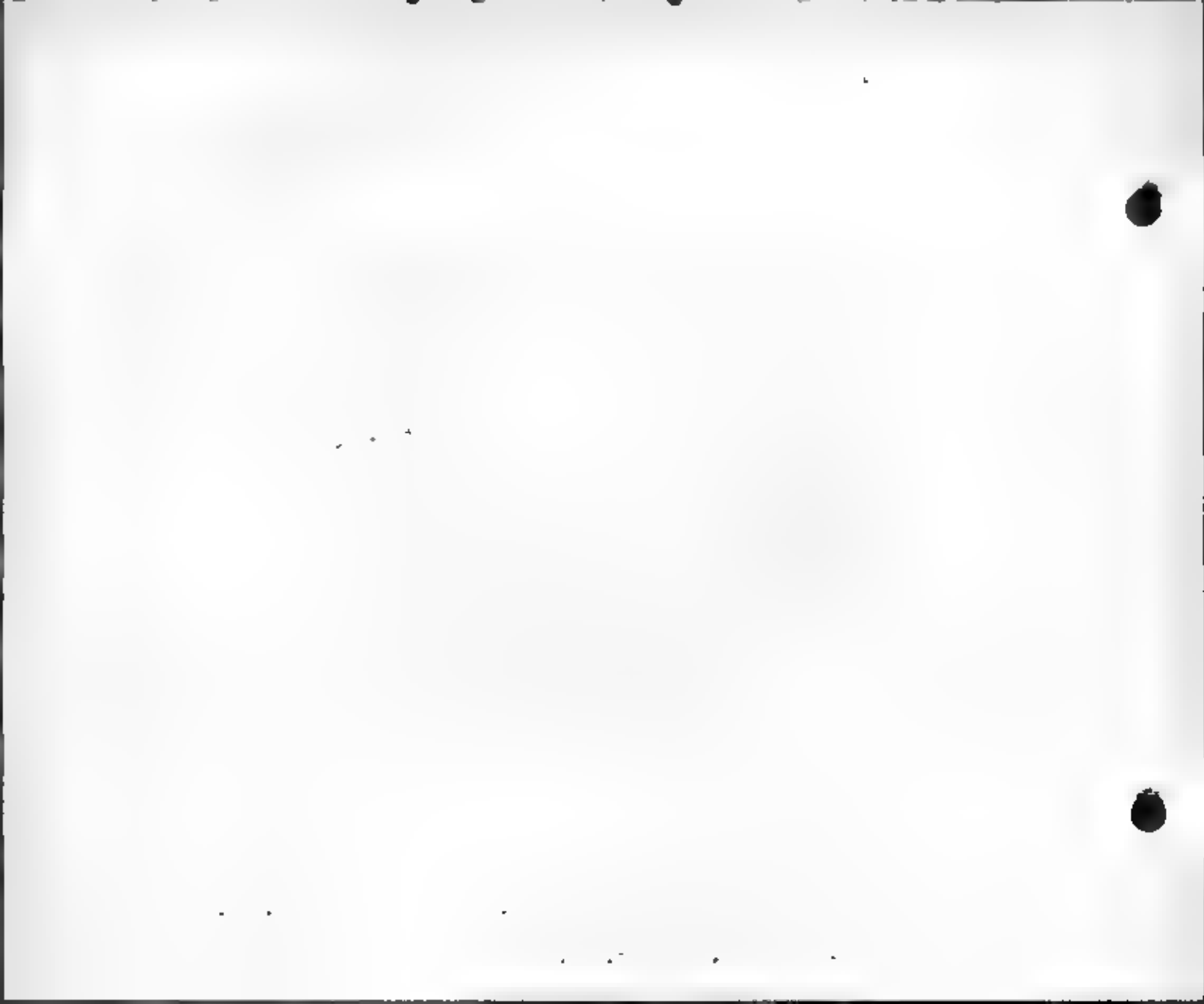
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOT BY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year 19 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 26, 1967 to JUNE 2, 1967 that (I) (we) last saw the deceased alive on JUNE 2, 1967 and that death occurred at 4 M. from the causes and on the date stated above.

22a. SIGNATURE Samuel I Smarkey 22b. DATE SIGNED JUN 30, 1967
22c. PHYSICIAN'S NAME (Type) SAMUEL I SMARKEY 22d. ADDRESS 1513 E. CHESAPEAK BLVD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/3/67 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. 23d. LOCATION (City, town or county) (State) Balto, Md.

24. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto, Md. 25a. REC'D BY REGISTRAR JUL 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge



07813

CERTIFICATE OF DEATH

57195

1 PLACE OF DEATH a COUNTY <u>Baltimore County</u> MARYLAND		2 USUAL RESIDENCE Where deceased lived at last illness a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN If outside corporate limits, write R.R. and give nearest town		c CITY OR TOWN If outside corporate limits, write R.R. and give nearest town	
d NAME OF HOSPITAL OR INSTITUTION If patient hospitalized, give street address <u>Baltimore General Hosp.</u>		d STREET ADDRESS <u>1222 S. Carey St.</u>	
3 NAME OF DECEASED (Type in print) <u>William A. Kolb</u>		4 DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/18/84</u>
9a AGE AT DEATH Give kind of work done during most of working life, even if retired <u>retired</u>		9b KIND OF BUSINESS OR INDUSTRY	
10 FATHER'S NAME <u>Late - Louis</u>		11 MOTHER'S MAIDEN NAME <u>Barbara Hammerbacher</u>	
12 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes give war or dates of service)		13 SOCIAL SECURITY NO <u>Medicare 215-01-2565</u>	
14 INFORMANT <u>Merrill B. Kolb-8900 Flagstone Rd. A-Randallstown</u>			
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Heart Failure</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH IF OTHER, NOTIFY MEDIA, EXAMINER		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)	
20c TIME OF INJURY Month, Day Year Hour <u>pm</u> 19 <u>67</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY Home, farm, factory, street, office, bldg., etc.	20f (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <u>6-5-67</u> to <u>6-6-67</u> that, (we last saw the deceased alive on <u>6-6-67</u> and that death occurred at <u>1:30</u> M. from causes and on the date stated above			
22a SIGNATURE <u>[Signature]</u> M.D.		22b DATE SIGNED <u>6-6-67</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, or other disposition of body	23b DATE OF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>BURIAL</u>	<u>6/9/67</u>	<u>Loudon Park Cem.</u>	<u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a REC'D BY REGISTRAR DATE <u>JUN 9 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove "page 3" from page 4. Pages of this certificate should be filed with the State Dept. of Health prior to burial, cremation or removal, and none should be filed with the State Dept. of Health after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07814

CERTIFICATE OF DEATH

07736

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>30 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission: a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> <u>21207</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>BALTO. CO. GEN. Hosp</u>		d. STREET ADDRESS <u>3636 Lochearn Dr.</u>	
3. NAME OF DECEASED Type or print: <u>Richard G. Krickhan</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1967</u>	
SEX <u>M</u>	d. COLOR OR RACE <u>W</u>	e. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	f. DATE OF BIRTH <u>9-16-84</u>
10a. IS JOB OF DECEASED (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>BOO. RR</u>	10c. BIRTHPLACE (county & state or foreign country) <u>MARYLAND</u>
3. FATHER'S NAME <u>Richard G. Krickhan</u>		14. MOTHER MAIDEN NAME <u>Bushman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hosp. Record</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> CONDITION (if any which gave rise to immediate cause of death) (b) <u>Generalized Atherosclerosis</u> UNDERLYING CAUSE (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I) <u>Bronchopneumonia, RLL</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If OTHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-16-1967</u> to <u>6-14-1967</u> , that (I) (we) last saw the deceased alive on <u>6-14-1967</u> and that death occurred at <u>6:30 AM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Antonio R. Jara</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MFD. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-14-67</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6/17/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore County MD</u>
24. FUNERAL DIRECTOR <u>E S Mac Nabb</u>		25a. FIELD BY REGISTRAR <u>JUN 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Antonio R. Jara</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial form. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The following requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers, pages 1 and 2, should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 4
25M 1 0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

67.97

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b. 7mths17dys		2. USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS none		f. IS RESIDENCE OR A ARMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Type of print First Alma Middle K Last Kruger		4. DATE OF DEATH Month June Day 29 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1894	9. AGE a. years 73 b. birthday 15	10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Mins 15
11. OCCUPATION (Give kind, work done during last of working life even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State or foreign country) Germany	
14. FATHER'S NAME FRANK J. KRUGER		15. MOTHER'S M maiden name ROTHMANN		16. IT IS THAT OF WHAT COUNTRY? U.S.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war and dates of service)		18. SOCIAL SECURITY NO. 093-07-6587		19. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
20. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary emboli H65X DUE TO Conditions, if any, which gave rise to immediate cause or hastened the underlying cause last b. DUH TO				21. INTERVAL BETWEEN DEATH AND REPORT 18 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (INDICATE IN PART I OR PART II OF ITEM 8) Decubitus ulcers				22. WAS A DEATH CERTIFICATE PREVIOUSLY ISSUED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. PRESENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH IF THE NUTRITION DIAL EXAMINER		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8)		24. IF INJURY IN PART I OR PART II OF ITEM 8, PLACED IN INJURY HOME OR INJURY PLACED IN INJURY HOME	
25. TIME OF INJURY Month Day Year Hour Min P.M. 9		26. SEX OF INJURED White <input type="checkbox"/> Not White <input type="checkbox"/> or work <input type="checkbox"/>		27. PLACE OF INJURY Home <input type="checkbox"/> or work <input type="checkbox"/> or other <input type="checkbox"/>	
28. I certify that (a) this hospital attended the deceased from Nov. 10 1966 to JUNE 29 1967 that (b) we last saw the deceased alive on JUNE 29 1967 and that death occurred at 1 A M from cause and on the date stated above					
29. SIGNATURE Anthony J. Young, M.D.		30. ATTENDING PHYSICIAN <input type="checkbox"/> M.D. <input type="checkbox"/> PRETOR <input type="checkbox"/> AFF. <input checked="" type="checkbox"/> 6-29-67		31. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
32. BURIAL OR CREMATION REMOVAL PERMIT 7/3/67		33. NAME OF CEMETERY OR CREMATORY BALTO. MC		34. LOCATION City or Town BALTO County MD	
35. FUNERAL DIRECTOR WILLIAM E. JONES		36. ADDRESS 300 MACLE		37. REG. BY REGISTRAR JUL 3 1967	
				38. REGISTRAR'S SIGNATURE Johnas Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chain papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after burial.

VR A15 (4)
2DM /65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 361 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07817											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RJRA, and give nearest town) <u>Catonville</u>						c. LENGTH OF STAY IN ID <u>7 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1967 Tadcaster Rd.</u>						e. STREET ADDRESS <u>1907 Tadcaster Rd</u>					
3. NAME OF DECEASED (Type or print) <u>George S. Lang</u>						4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1945</u>		9. AGE (In years last birthday) <u>21 yrs.</u>		F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garmentant</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. C. TIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilson S. Lang</u>						14. MOTHER'S MAIDEN NAME <u>Annie M. Powers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>						16. SOCIAL SECURITY NO. <u>217-09-6834</u>		17. INFORMANT <u>Bessie Lang</u> Address <u>1907 Tadcaster Rd.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Mel. of the larynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>67</u> to <u>June 12</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>June 12</u> 19 <u>67</u> and that death occurred at <u>11:33 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W. S. M. Ray</u>						22b. DATE SIGNED <u>JUNE 14, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. S. M. Ray</u>						22d. ADDRESS <u>6014 Edmondson Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenacres Cemetery</u>		23d. LOCATED ON (City, town or county) <u>Baltimore</u> (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR <u>Ambrose Jones</u> Address <u>22x Sulphur Sp. Rd</u>						25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATE OR



27818

CERTIFICATE OF DEATH

2720

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Salto</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1967</u>		5. DATE OF BIRTH Month <u>June</u> Day <u>19</u> Year <u>1900</u>		6. AGE in years at birthday <u>67</u>	
7. SEX <u>Male</u>		8. COLOR OR RACE <u>White</u>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3005 Mount Rd.</u>		12. STREET ADDRESS <u>3005 Mount Rd.</u>		13. IS RESIDING ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. BIRTHPLACE (County & State or foreign country) <u>Salto, Md.</u>	
15. FATHER'S NAME <u>James E. Stewart</u>		16. MOTHER'S MAIDEN NAME <u>Sarah Gourley</u>		17. WAS DECEASED EVER IN ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>1-10-10-10-10-10</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart disease</u>		20. DUE TO CONDITION (if any which gave rise to immediate cause (a), stating the underlying cause) <u>Coronary artery disease</u>		21. DUE TO <u>Heart disease</u>		22. NERVOUS BETWEEN ONSET AND DEATH <u>Yes</u>	
23. PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>None</u>		24. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25. AC. DEATH WAS UNDERLYING OR ON RIBBING? CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		26. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
27. TIME OF INJURY Month, Day, Year Hour <u>10</u> AM <u>19</u>		28. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		29. PLACE OF INJURY Home, farm, factory, street, office bldg, etc., <u>Home</u>		30. (City or town) (County) (State) <u>Salto, Md.</u>	
31. I certify that (this hospital) attended the deceased from <u>June 19, 1967</u> to <u>June 23, 1967</u> that (I) (we) saw the deceased alive on <u>June 19, 1967</u> and that death occurred at <u>3:00 PM</u> from causes and on the date stated above.							
32. SIGNATURE <u>Charles E. Carr, Jr.</u>		33. PHYSICIAN'S NAME (Type) <u>CHARLES E. CARR JR</u>		34. ADDRESS <u>3900 N. Charles St.</u>		35. DATE SIGNED <u>6/24/67</u>	
36. BIRTH INFORMATION (Specify) <u>Bureau</u>		37. DATE THEREOF <u>June 19, 1967</u>		38. NAME OF CEMETERY OR CRIMATORY <u>St. Mary's Cemetery</u>		39. LOCATION (City or town) (County) (State) <u>Salto, Md.</u>	
40. FUNERAL DIRECTOR <u>Thomas J. Henry, Inc. 1600 Holmes St.</u>		41. ADDRESS <u>1600 Holmes St.</u>		42. REC'D BY REGISTRAR <u>Charles Judge</u>		43. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please provide urban papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy given to the family. In 72 hours after death

VR A 5 41
20 M '66



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07801

07813

FOR STATE HEALTH DEPT.

PLACE OF DEATH

a. COUNTY

Baltimore

MARY AND

7. USUAL RESIDENCE (Where deceased resided if not in residence before death)

a. STATE

Maryland

b. COUNTY

A.A. Co.

b. CITY OR TOWN (If not in separate limits write RURAL and give nearest town)

LENGTH OF STAY IN IL

c. CITY OR TOWN (If burial place write RURAL and give nearest town)

Severna Park, MD

d. NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address)

Baltimore General Hospital

e. STREET ADDRESS

Rt 2, Box 262

f. RACE

W

NAME OF DECEASED

Homer - Lawson

4. DATE OF DEATH

6/12/67

SEX

M

6. COLOR OR RACE

C

7. MARRIED

☒ NEVER MARRIED

8. DATE OF BIRTH

5/26/14

9. AGE (In years last birthday)

53

10. MONTHS

11. DAYS

12. HOURS

13. MIN

14. OCCUPATION (If deceased was not working at time of death, give last occupation)

Social Security Admin.

15. KNOWN BUSINESS OR INDUSTRY

Montgomery, Ala.

16. COUNTRY

USA

17. a. HER NAME

Benjamin - Lawson

4. MOTHER'S NAME

Unknown

18. b. ADDRESS (If deceased was not living at time of death, give last address)

Unknown

19. INFORMANT

Thelma Lawson

20. ADDRESS

Same

21. CAUSE OF DEATH

PART DEATH WAS CAUSED BY

Immediate Cause (a) Acute Myocardial Infarction

22. OUTLINE

Condition if any which gave rise to the immediate cause

23. INTERVAL BETWEEN

Death

24a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CON RIBUTING ☐ CAUSE OF DEATH

24b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of item 8.)

25. TIME OF INJURY Month Day Year

26. IN THE CITY

27. PLACE OF INJURY (Home farm factory street, office bldg, etc.)

28. I certify that death resulted from ☒ Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner

29. ACTUAL EXAMINER

James H. Frederick

30. EXAMINER'S NAME

J. N. Frederick MD

31. DISTRICT EXAMINER

32. ASSISTANT MEDICAL EXAMINER

33. PUBLIC HEALTH EXAMINER

34. ADDRESS

1311 Francis Ave

Baltimore 22

35. b. CITY OR TOWN

36. NAME OF DECEASED

37. ADDRESS

38. FUNERAL DIRECTOR

39. ADDRESS

40. REC'D BY REGIS. RAR

DATE JUN 14 1967

41. REGIS. TRAINER'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER

ne necessary, please send the certificate to the funeral director, page 4 should be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. If a pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A SWF 6M 67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07820

CERTIFICATE OF DEATH

07802

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere c. LENGTH OF STAY IN 1b 8 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2619 Edgemere Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere d. STREET ADDRESS 2619 Edgemere Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert F. Lee Jr. First Robert Middle F. Last Lee Jr.		4. DATE OF DEATH June 14 1967 Month June Day 14 Year 1967	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> W. DOWED <input type="checkbox"/>		8. DATE OF BIRTH 1/19/16 9. AGE (in years last birthday) 51 yrs. 10. IF UNDER 1 YEAR: Months 11 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant in Hospital 10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert F. Lee Sr.		14. MOTHER'S MAIDEN NAME Maggie Gregory	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 228-24-6767	
17. INFORMANT (Sister) Mrs. Louise McCully Address 2619 Edgemere Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Pulmonary emphysema PART II. OTHERS ON F-CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year 19 Hour a.m. p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. (City or town) Baltimore (County) Baltimore (State) Md.		20f. (City or town) Baltimore (County) Baltimore (State) Md.	
21. I certify that (i) (this hospital) attended the deceased from July 10 1961 to June 14 1967 , that (i) (we) last saw the deceased alive on June 13 1967 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John V. Conway 22c. PHYSICIAN'S NAME (Type) John V. Conway		22b. DATE SIGNED 6/15/67 22d. ADDRESS 911 "D" St. Sparrows Point, Md. 21219	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland (State) Md.	
24. FUNERAL DIRECTOR John J. Duda Address 7922 Wise Ave. Dandak, Md.		25a. REC'D BY REGISTRAR JUN 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

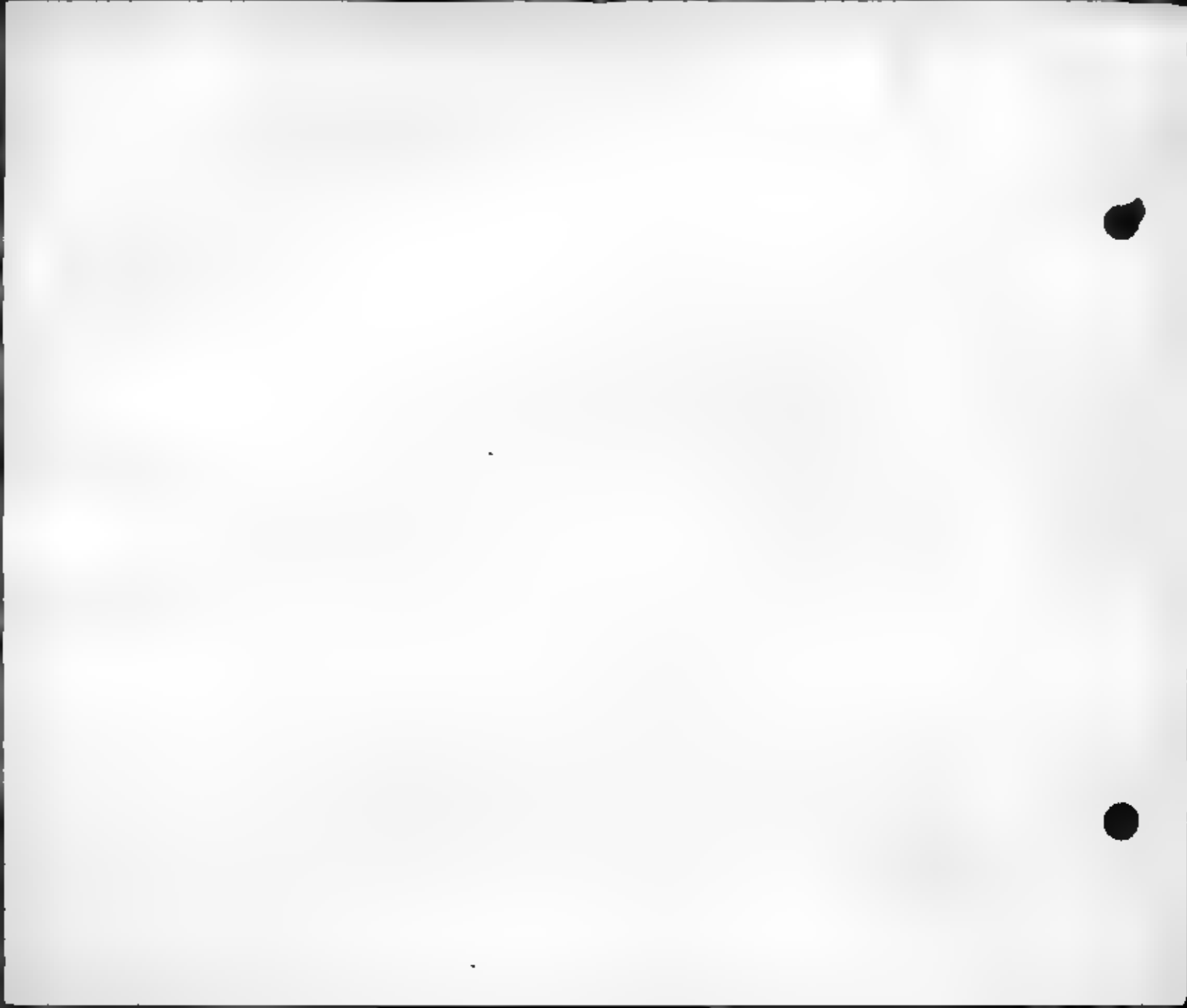
57803

FOR STATE
HEALTH DEPT.

07821

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. STATE		b. COUNTY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. NAME OF DECEASED (Type or print)		f. DATE OF DEATH	
g. SEX		h. AGE (In years, last birthday)	
i. COLOR OR RACE		j. IF UNDER 1 YEAR	
k. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		k. IF UNDER 24 HRS	
l. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		l. Month Days Hours Min	
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		m. BIRTHPLACE (State or foreign country)	
n. KIND OF BUSINESS OR INDUSTRY		n. CITIZEN OF WHAT COUNTRY	
o. FATHER'S NAME		o. MOTHER'S MAIDEN NAME	
p. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or date of service)		p. SOCIAL SECURITY NO	
q. CRUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		q. ADDRESS	
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a))		INTERVAL BETWEEN ONSET AND DEATH	
b. DUE TO		r. WAS AUTOPSY PERFORMED?	
c. DUE TO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		s. DATE SIGNED	
t. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		t. DEPUTY MEDICAL EXAMINER	
u. TIME OF INJURY Month Day Year		u. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
v. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work		v. CITY or town	
w. I certify that look charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		w. (County) (State)	
Nature, causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		x. ACTUAL SIGNATURE	
y. EXAMINER'S NAME (Type)		y. DATE SIGNED	
z. BURIAL, CREMATION, REMOVAL (Specify)		z. NAME OF CEMETERY OR CREMATORY	
aa. DATE THEREOF		aa. LOCATION (City, town, or county)	
ab. FUNERAL DIRECTOR		ab. REGISTRAR'S SIGNATURE	
ac. ADDRESS		ac. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07822

07804

I. PLACE OF DEATH

a. COUNTY

BALTIMORE

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BALTIMORE

c. LENGTH OF STAY IN MD

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

344 Rippled

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

a. STATE

MARYLAND

b. COUNTY

BALTIMORE

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BALTIMORE

d. STREET ADDRESS

344 Rippled

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

ROYAL

Middle

Last

LEIKIN

4. DATE OF DEATH

Month

JUNE

Day

6

Year

1967

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

NOV. 24, 1893

9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS.

73⁷³ Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTH

12. CITIZEN OF WHAT COUNTRY?

NEW BRITON, TENN

USA

13. FATHER'S NAME

BERNARD

4. MOTHER'S MAIDEN NAME

FREDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

215-10-1893

INFORMANT

FRANCES LEIKIN

Address

SAME

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE

DUE TO

Acute Myocardial Infarction
Coronary Artery Disease

Conditions if any which gave rise to immediate cause (to stating the underlying cause last)

DUE TO

IC

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? IF EITHER NOTIFY MEDICAL EXAMINER

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II as item 18)

21c. TIME OF INJURY (Month Day Year) Hour a.m. p.m.

21d. INJURY OCCURRED (White Not White at work at work)

21e. PLACE OF INJURY (Home farm, factory, street, office, bldg, etc.)

21f. City or town

(County)

(State)

21. I certify that (this hospital) attended the deceased from 1960 to 6/6, 1967 that (I) (we) saw the deceased alive on 6/5, 1967 and that death occurred at 7:00 AM from the causes and on the date stated above.

22a. SIGNATURE OF

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYSICIAN

MED. DIRECTOR ☐

STAFF PHYSICIAN ☐

22d. ADDRESS

4300 LEBLANC AVE, A

22e. DATE SIGNED

6/6/67

23a. BURIAL CREMATION (Specify)

BURIAL

23b. DATE THEREOF

6/8/1967

23c. NAME OF CEMETERY OR CREMATORY

HAR SINCE

23d. LOCATION (City, town or county)

QUINCY MILLS

State

MD

24. FUNERAL DIRECTOR'S SIGNATURE

SILVIA S. LEWIS + SON INC

ADDRESS

GARRISON, MD

25a. REC'D BY REGISTRAR

JUN 9 1967

25b. NOTEPAR SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FLUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial "transfer permit". Then please remove carbon papers and file the original with the State Dept. of Health prior to burial. A death certificate should be filed with the State Dept. of Health prior to burial.

VR A 5 4
25A 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

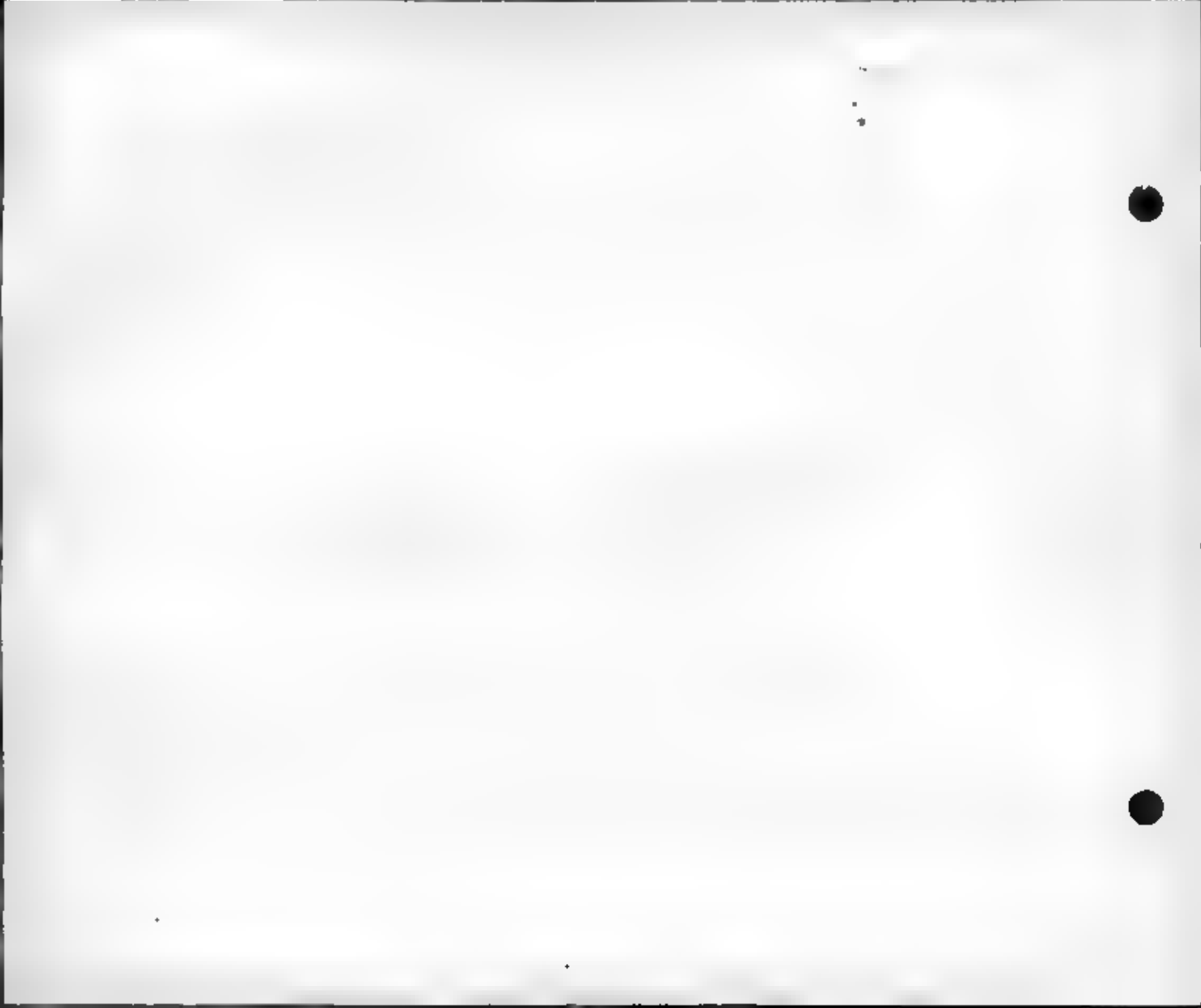
07823

CERTIFICATE OF DEATH

07805

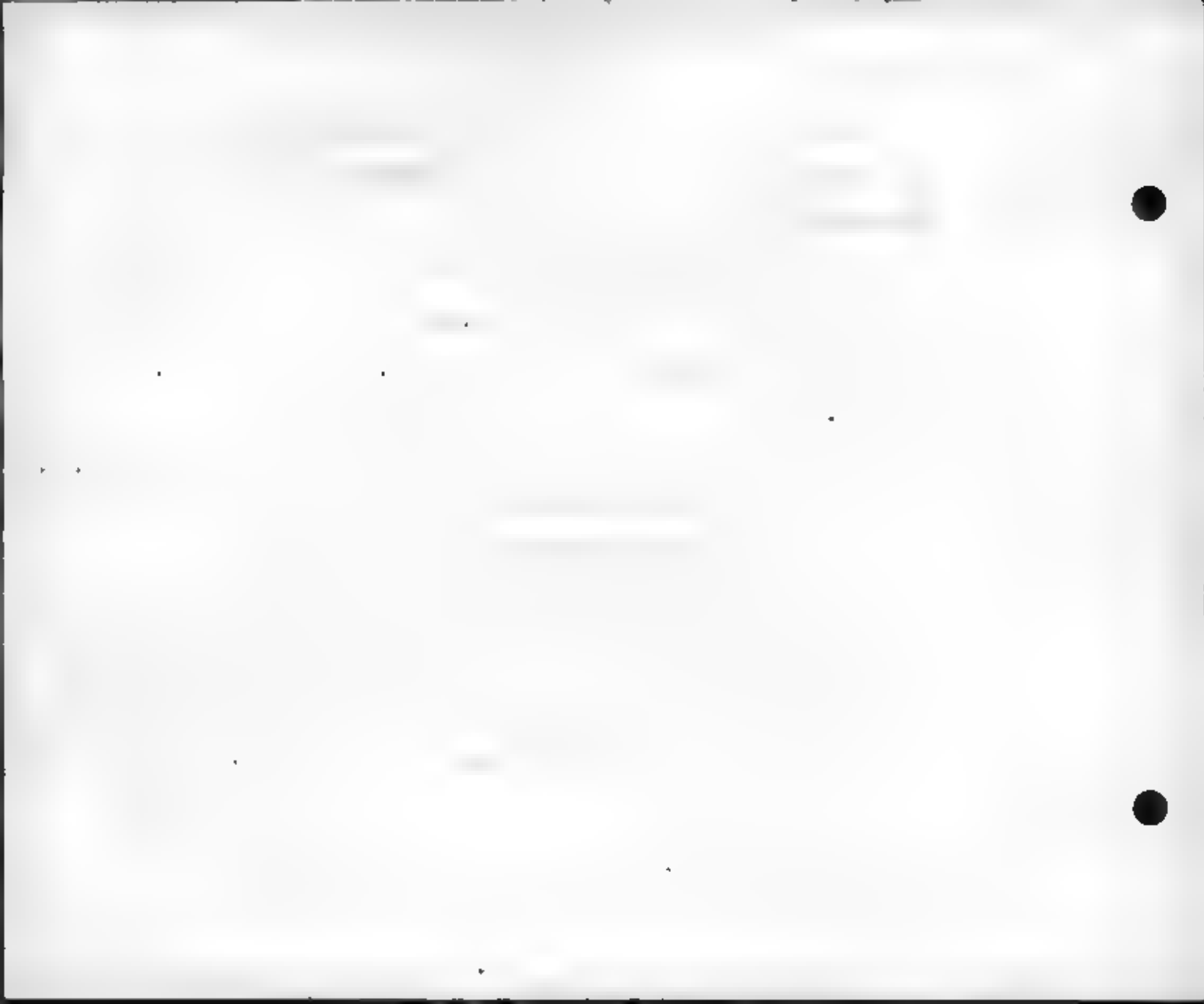
1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Catonsville c DISTRICT OR TOWNSHIP If outside corporate limits, write RURAL and give nearest town Smiths5dys		2 USUAL RESIDENCE (Where deceased lived if in institution: Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Lansdowne, Maryland	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSPITAL		4 STREET ADDRESS 320 Fourth Avenue 5 IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
6 NAME OF DECEASED First Middle Last Mary W. Lewis		7 DATE OF DEATH Month Day Year June 21 1967	
8 SEX female	9 COLOR OR RACE white	10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11 DATE OF BIRTH May 26, 1883
12 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		13 AGE in years, months, days, hours, minutes 84	
14 KIND OF BUSINESS OR INDUSTRY housewife		15 BIRTHPLACE (County & State or foreign country) Maryland	
16 FATHER'S NAME John Hooper		17 MOTHER'S MAIDEN NAME Winifred Hooper	
18 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		19 SOCIAL SECURITY NO.	
20 INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
21 CAUSE OF DEATH (Print only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY a IMMEDIATE CAUSE (a) 04 DUE TO b PERMANENT CAUSE (b) c UNDERLYING CAUSE (c) conditions - any which gave rise to immediate cause or, stating the underlying cause to it Peritonitis, generalized, organism unk. 3 days Perforated intestine 3 days Fecolith and diverticulitis unknown		22 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) Bronchopneumonia, bilateral, organism undetermined	
23a MENTAL INJURY UNDER MINOR OR CONTRIBUTING CAUSE OF DEATH (IF FATHER NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19		23b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 23c PLACE OF INJURY Home farm factory street, office bldg, etc. 23d (City or town) (County) (State)	
24 I certify that (X) this hospital attended the deceased from Jan. 16 1967 to June 21 1967 that (X) we last saw the deceased alive on June 21 1967 and that death occurred at 1:55 P.M. from causes and on the date stated above			
25a SIGNATURE Anthony J. Young, M.D.		25b ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
26a BURIAL, CREMATION, REMOVAL (Specify) Burial		26b DATE THEREOF 6/24/67	
27a NAME OF CEMETERY OR CREMATORY Loydon Park		27b LOCATION (City or town) (County) (State) Baltimore, Md.	
28a FUNERAL DIRECTOR Wm. Cook-Brooks Inc, Baltimore, Md. 21202		28b REGISTRAR'S SIGNATURE MIN 2 9 1967	

MIN 2 9 1967



07806

2501 147



97825

27807

[illegible]

48 A 5 4)
25M 57



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached and used as the burial-transit permit. Then please remove all stamps. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 5-61
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07826

CERTIFICATE OF DEATH

07808

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Catonsville		2 USUAL RESIDENCE Where deceased lived if institution a. STATE Maryland b. COUNTY Baltimore	
c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town		d. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town	
e. LENGTH OF STAY IN b 2yr7mthldy		f. STREET ADDRESS 1055 Maiden Choice Lane	
3 NAME OF DECEASED Type or print Lenora RITA Lisowski		4 DATE OF DEATH Month June Day 8 Year 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 2, 1919
9 AGI In years last birthday 47		10 IF UNDER 1 YEAR Months 4 Day 7	
11 IF UNDER 24 HRS. Hours 11 Minutes 00		12 IF UNDER 24 HRS. Hours 11 Minutes 00	
13 FATHER'S NAME Anthony Monroe		14 MOTHER'S MAIDEN NAME Sophia Czerwinski	
15 WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. 214-12-9100	
17 INFORMANT Records: SPRING GROVE STATE HOSPITAL		18 ADDRESS SPRING GROVE STATE HOSPITAL	
19 CAUSE OF DEATH (Enter only one cause per line for 19a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 470X DUE TO Conditions if any which gave rise to immediate cause stating the underlying cause (b) Bilateral pneumonia DUE TO (c)			
20 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
21 INTERVA BETWEEN ONSET AND DEATH			
22 MEDICAL CERTIFICATION 22a. DATE OF INJURY Month Day Year Hour:am p.m. 9 22b. INJURY OR IMPRECISE <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 22c. PLACE OF INJURY Home room <input type="checkbox"/> Factory street, office bldg, etc. <input type="checkbox"/> 22d. CITY OR TOWN Baltimore County Baltimore State Md			
23 I certify that (a) this hospital attended the deceased from Nov. 7 1965 to June 8 1967 and that the deceased died on June 8 1967 and that the death occurred at 1145 M. from causes and at the date stated above.			
24 SIGNATURE Stella Wachslor M.D. 24a. PHYSICIAN'S NAME Type Stella Wachslor, M.D.		25 ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
26 DATE OF DEATH 6/12/67		27 NAME OF CEMETERY OR BURIALITY Trinity Cemetery	
28 LOCATION City or town Baltimore County Baltimore State Md		29 RECORD BY REGISTRAR Charles Judge	
30 DATE JUN 9 1967		31 SIGNATURE Charles Judge	

18, 20



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

97827

CERTIFICATE OF DEATH

97883

PLACE OF DEATH a. COUNTY BALTO.		USUAL RESIDENCE (where deceased lived if in institution; Residence before admission) a. STATE Md b. COUNTY BALTO.	
b. CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" CATONSVILLE		c. CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION "If not in hospital give street address" 6125 Wheatland Rd		e. STREET ADDRESS 6125 Wheatland Rd	
3. NAME OF DECEASED (Type or print) Charles Raymond Loomis		4. DATE OF DEATH Month JUNE Day 12 Year 1967	
SEX M	b. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1905
On 1/1/67, OCCUPATION (Give kind of work done during week of working; if ever retired) CARPENTER		10. BIRTHPLACE County & State or foreign country BALTO.	
1. FATHER'S NAME Charles L Loomis		4. MOTHER'S M maiden NAME BERTHA E Wieneke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes no or unknown; If yes give war or dates of service) NO		16. SOCIAL SECURITY NO Adelaide Loomis 6125 Wheatland Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY (a) IMMEDIATE CAUSE of DEATH (b) MATRIMONIAL TO THE LIVES Conditions, if any, which gave rise to immediate cause of death, stating the underlying cause (c) ...		19. WHAT BETWEEN DEATH AND DEATH ...	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I ...		9. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. (1) DEATH WAS INDUCED BY OR CONTRIBUTING CAUSE OF DEATH IF KNOWN, NOTIFY MEDICAL EXAMINER		20b. (2) SURVIVOR HOW INJURY OCCURRED (Enter nature of injury in Part III or Part II, item 8)	
20c. (3) DATE OF INJURY Month Day Year Hour am pm ...	20d. INJURY OCCURRED While <input type="checkbox"/> No While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY Home farm factory street office other ...	
21. I certify that (this hospital) attended the deceased from ... 19 67 to ... 19 67 , that (I) (we) last saw the deceased alive on ... 19 67 and that death occurred at ... M from causes and on the date stated above		22a. SIGNATURE Kenward Yaffe	
22b. PHYSICIAN'S NAME (Type) KENWARD YAFFE		22c. ADDRESS 5501 FOREST PARK AVE	
23a. BURIAL, CREMATION, REMOVAL, SPECIES BURIAL	23b. DATE THEREOF 6/15/67	23c. NAME OF METEY OR R MATORY DRUID RIDGE	23d. "X" A "X" B City or town County State BALTO. Md
24. FUNERAL DIRECTOR E S McNeill		25a. REF BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Johnas J...			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the registrar, director page 3 should be detached for use as the burial-transit permit. Then please remove green paper pages on 2 and 3 and should be filed with the State Dept of Health in proper to burial, cremation or removal, and only permit with a 22 hour after death.



TO HOSPITAL OR ATTEND NG PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove a bon page 1, pages 2 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and in payment with 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07828

CERTIFICATE OF DEATH

07-30

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville		c STATE Maryland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e STREET ADDRESS 3328 Fleet Street	
3 NAME OF DECEASED (Type at print) Rose Lyons		4 DATE OF DEATH June 24 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 23, 1900
9a PLACE OF BIRTH (Give kind of work done during most of last 12 months even if abroad) Housewife		9b KIND OF BUSINESS OR INDUSTRY	
10 FATHER'S NAME Frederick Dorsch		11 MOTHER'S MAIDEN NAME Elizabeth Becker	
12a SOCIAL SECURITY NO 219-54-3220-T		13 INFORMANT RECORDS: Spring Grove State Hospital	
14 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Myocardial Infarction, Acute, Death b. Arteriosclerotic Cardiovascular Heart Dis. 1 mon. c. Arteriosclerosis, Generalized, Senile 10 yrs.		15 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) Imp. Cellulitis, right leg, organism unknown, tx. with Keflin.	
16a TIME OF INJURY Month, Day, Year June 24 1967		16b INJURY A SURFED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>	
17a TIME OF INJURY Month, Day, Year June 24 1967		17b PLACE OF INJURY Home, Farm, Factory, Street, Publicly, etc. Spring Grove State Hospital	
21 I certify that this hospital attended the deceased from 1-11-30 to June 24 1967 that we last saw the deceased alive on 6-24-67 and that death occurred at 6:00 P.M. from arteriosclerosis and on the date stated above		22a SIGNATURE Anthony J. Dorsch, M.D.	
22b PHYSICIAN NAME (Type) Anthony J. Dorsch, M.D.		22c ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a BURIAL, CREMATION, REMOVAL, etc. BURIAL	23b DATE THEREOF 6-29-67	23c NAME OF CEMETERY OR CREMATORY OK LAWN CEM.	23d LOCATION (City or Town) (County) (State) 7225 EASTERN BLVD. BALTO., MD
24 FUNERAL DIRECTOR Charles S. Juler		25a REC'D BY REGISTRAR JUN 30 1967	
25b REGISTRAR'S SIGNATURE Charles S. Juler		25c REGISTRAR'S SIGNATURE Charles S. Juler	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07823

CERTIFICATE OF DEATH

07811

1. PLACE OF DEATH a. COUNTY Baltimore		b. STATE Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN ID. 4y52mth10dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 301 S. St. John's Lane		e. S. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type in print) Bertha Lillian Mabry				f. DATE OF DEATH Month June Day 12 Year 1967			
SEX Female		g. COLOR OR RACE White		MARITAL STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		h. DATE OF BIRTH April 15, 1906	
i. AGE in years, months, days 61		j. IF UNDER 1 YEAR Month 12 Day 12 Hour 12 Min 12		k. IF UNDER 1 YEAR Month 12 Day 12 Hour 12 Min 12		l. IF UNDER 1 YEAR Month 12 Day 12 Hour 12 Min 12	
m. n. OCCUPATION (Give kind of work done during most of work to the even if retired) Housewife		o. p. KIND OF BUSINESS OR INDUSTRY Pa.		q. BIRTHPLACE (Give county & state or foreign country) Pa.		r. s. COUNTRY OF BIRTH U.S.A.	
3. FATHER'S NAME Howard Smith				4. MOTHER'S MAIDEN NAME Lillian Murphy			
v. WA. DI. CASEL. FWRIN. S. ARMED FORCES? (Yes, no, or unknown) No		w. SOCIAL SECURITY NO. No		5. INFORMANT Records: Spring Grove State Hospital		Address Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: DEATH CAUSED BY IMMEDIATE CAUSE: a. Arteriosclerotic cardiovascular disease b. 4444 c. 4444 Conditions if any, which gave rise to immediate cause a, stating the underlying cause last b. 4444 c. 4444							IN 1 YEAR BETWEEN ONSET AND DEATH 1 yr.
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Cachexia							9. WA. AL. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING? <input type="checkbox"/> YES, OF DEATH OR EITHER, NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II at item 8					
20c. TIME OF INJURY Month Day Year Hour: am 9 p.m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (this hospital) attended the deceased from April 2, 1963 to June 12 1967 that we last saw the deceased alive on June 12 1967 and that death occurred at 2:25 M. from causes and on the date stated above							
22a. SIGNATURE Stella Wachslar		M.D. ATTENDING PHYS. <input type="checkbox"/> W.F.D. DIRECTOR <input type="checkbox"/> TAFE PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-12-67			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228					
23a. BURIAL OR CREMATION REMOVAL SPECIFY Burial		23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		25. REC'D BY REGISTRAR JUN 15 1967		26. REGISTRAR'S SIGNATURE J. J. J. J.	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7830

07812

1. NAME OF DECEASED: **MARKIEWICZ, LAURA HELEN** 12. DATE AND HOUR OF DEATH: **6/24/67 2:00 P**

PLACE OF DEATH: **MARYLAND**

FULL NAME OF DECEASED: **MARKIEWICZ, LAURA HELEN**

101 BEAUMONT AVE
CATONSVILLE MD 21228

SEX: **F** RACE: **W** MARRIED: **NEVER MARRIED**

10A USUAL OCCUPATION: **HOUSEWIFE**

3. FATHER'S NAME: **RACHUBA**

5. Was Deceased Ever in U.S. Armed Forces? **No**

6. SOCIAL SECURITY NO: **217-38-5057**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: **CHRONIC PYELONEPHRITIS**

19. CAUSE OF DEATH: **LEFT NEPHRECTOMY**

20. UREMIA

21. INTERVAL BETWEEN ONSET AND DEATH: **~ 2 1/2 y**

22. I certify that I (this physician) attended the deceased from **6/19/67** to **6/24/67**

23. I last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

24. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

25. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

26. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

27. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

28. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

29. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

30. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

31. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

32. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

33. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

34. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

35. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

36. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

13. RESIDENCE: **MARYLAND, BALTIMORE**

14. CITY OF TOWN: **CATONSVILLE**

15. STREET ADDRESS: **101 BEAUMONT AVE**

16. DATE OF BIRTH: **11/3/1905**

17. BIRTHPLACE: **BALTIMORE, MD**

18. CITIZEN OF WHAT COUNTRY: **U.S.A**

19. MOTHER'S MAIDEN NAME: **VERONICA**

20. INFORMANT: **WILLIAM**

21. ADDRESS: **101 BEAUMONT AVE**

22. CAUSE OF DEATH: **CHRONIC PYELONEPHRITIS**

23. LEFT NEPHRECTOMY

24. UREMIA

25. INTERVAL BETWEEN ONSET AND DEATH: **~ 2 1/2 y**

26. I certify that I (this physician) attended the deceased from **6/19/67** to **6/24/67**

27. I last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

28. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

29. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

30. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

31. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

32. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

33. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

34. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

35. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

36. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

37. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

38. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

39. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

40. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

41. I (we) last saw the deceased on **6/23/67** and that (my) (our) opinion on death occurred on the date **6/24/67**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon pages 1 and 2 and return them to the funeral director. This certificate should be filed with the State Department of Health.

VR 5-54
25M '67

24A BURIAL CREMATION: **BURIAL**

24B DATE: **6/27/67**

24C NAME OF CEMETERY OR CREMATORY: **HILL RESORT**

24D LOCATION: **CLADYK MD**

24E NAME OF REGISTRAR: **F.S. MACHABE**

24F NAME OF REGISTRAR: **F.S. MACHABE**

24G NAME OF REGISTRAR: **F.S. MACHABE**

24H NAME OF REGISTRAR: **F.S. MACHABE**

24I NAME OF REGISTRAR: **F.S. MACHABE**

24J NAME OF REGISTRAR: **F.S. MACHABE**

24K NAME OF REGISTRAR: **F.S. MACHABE**

24L NAME OF REGISTRAR: **F.S. MACHABE**

24M NAME OF REGISTRAR: **F.S. MACHABE**

24N NAME OF REGISTRAR: **F.S. MACHABE**

24O NAME OF REGISTRAR: **F.S. MACHABE**



07831

CERTIFICATE OF DEATH

07813

PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If no wide corporate limits write RURAL and give nearest town) FORT HOWARD		c. STATE MARYLAND d. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE	
e. NAME OF HOSPITAL OR INS. (If not in hospital give full address) VETERANS ADMINISTRATION HOSPITAL		f. STREET ADDRESS 1111 GOODWOOD ROAD	
g. NAME OF DECEASED Type of print) First Middle Last WILLIAM A. MARSH		h. DATE OF DEATH Month Day Year JUNE 22, 1967	
i. SEX MALE j. COLOR OR RACE NEGRO		k. DATE OF BIRTH Month Day Year 2/7/11	
l. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		m. AGE IN YEARS at birthday 53	
n. OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		o. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND	
p. FATHER'S NAME HENRY MARSH		q. MOTHER'S MAIDEN NAME CARRIE BUTLER	
r. Was he ever in U.S. Armed Forces? (Yes no, or unknown. If yes give year of dates of service) YES WWII		s. INFORMATION Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
t. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE BRONCHOPNEUMONIA, BILATERAL, UNDETERMINED ORIGIN, RECENT DUE TO CONDITIONS IN ANY WHICH GAVE RISE TO IMMEDIATE CAUSE OR TO THE UNDERLYING CAUSE DUE TO NEOPLASM, UNDETERMINED ORIGIN, LUMBAR & THORACIC SPINE			
u. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Indicate with a, b, or c) PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
v. 2a. At DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If former, NOTIFY MEDICAL EXAMINER) 2b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of form B)		w. 2c. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) 2d. City or town, county, state	
x. 2e. TIME OF INJURY (Month, Day, Year) 2f. INJURY IN (Work, While at work, Not while at work)		y. 2g. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) 2h. City or town, county, state	
z. I certify that I attended the deceased from 2/22/67 to 6/22/67 and that death occurred on 6/22/67 at 9:15 PM from cause stated on the date stated above.			
aa. SIGNATURE NEILON NEILSON, M. D.		ab. DATE 6/23/67	
ac. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		ad. ADDRESS VAH FORT HOWARD, MARYLAND	
ae. BURIAL OR CREMATION (Specify) BURIAL		af. DATE THEREOF 6/27/67	
ag. NAME OF FUNERAL HOME BALTIMORE NATIONAL		ah. LOCATION (City and county) BALTIMORE, MARYLAND	
ai. FUNERAL DIRECTOR Wm. C. March Funeral Home 928 E. North Ave. Baltimore, Md.			

TO HOSPITAL ■ ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director or page 3 thereon, it should be filed with the State Dept. of Health prior to removal of the body. Then please remove carbon paper pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It is to be filled out by the medical examiner or the coroner, or by the physician in charge of the hospital or institution where the death occurred. It is to be forwarded to the State Department of Health, Baltimore, Maryland, for filing. The State Department of Health will issue a certificate of death to the funeral director. The funeral director will issue a certificate of death to the family. The State Department of Health will also issue a certificate of death to the family.

TO FUNERAL DIRECTOR: This certificate should be filled out by the medical examiner or the coroner, or by the physician in charge of the hospital or institution where the death occurred. It is to be forwarded to the State Department of Health, Baltimore, Maryland, for filing. The State Department of Health will issue a certificate of death to the funeral director. The funeral director will issue a certificate of death to the family. The State Department of Health will also issue a certificate of death to the family.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201

07832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07814

PLACE OF DEATH Baltimore		USUAL RESIDENCE Maryland	
Baltimore		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 3112 Remington Avenue	
NAME OF DECEASED JOHN JOSEPH MARTENS		DATE OF DEATH June 18, 1967	
SEX Male		AGE 25 yr	
RACE White		BIRTHPLACE U.S.	
OCCUPATION ROOFER		INDUSTRY ATLANTIC COAST	
FATHER'S NAME HOWARD V.		MOTHER'S MAIDEN NAME SOPHIA P.	
INFORMANT HOWARD V. MARTENS 3112 REMINGTON AVE			
CAUSE OF DEATH PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning		ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
CONDITION (if any) WHICH GAVE RISE TO IMMEDIATE CAUSE (b) DUE TO			
PART 2 OTHER SIGNIFICANT CAUSE OF DEATH (c) Drowning while swimming in quarry			
DATE OF DEATH Unk 6/18/67		Baltimore, Md	
21 certify that the death of the deceased was due to the cause stated above and that the death resulted from		Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Other <input type="checkbox"/>	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME		DATE SIGNED 6/19/67	
Burial JUN 22 1967		HEARNSHIDE ELK RIDE MD	
Burial JUN 22 1967		3617 Chestnut Ave.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

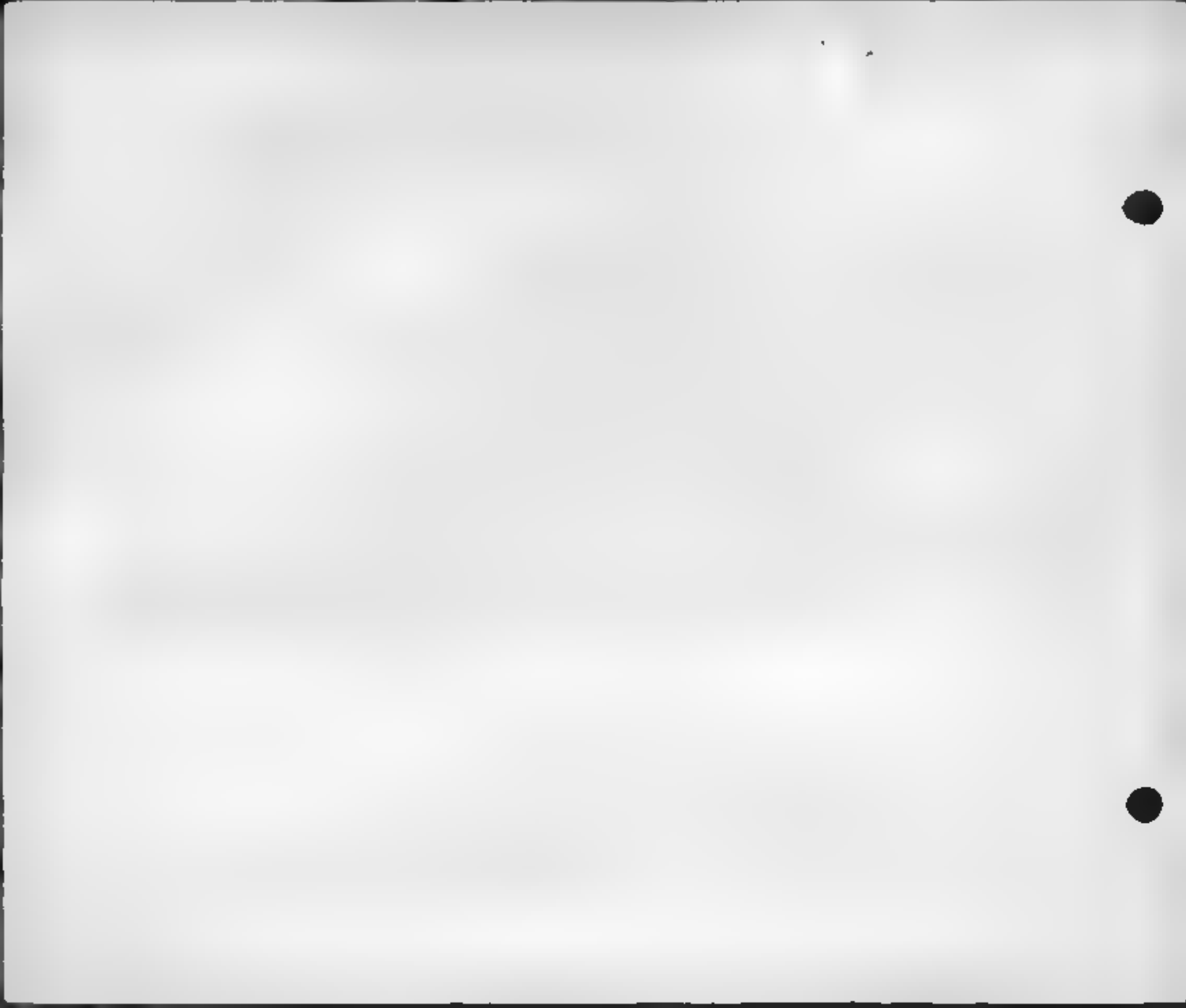
CERTIFICATE OF DEATH

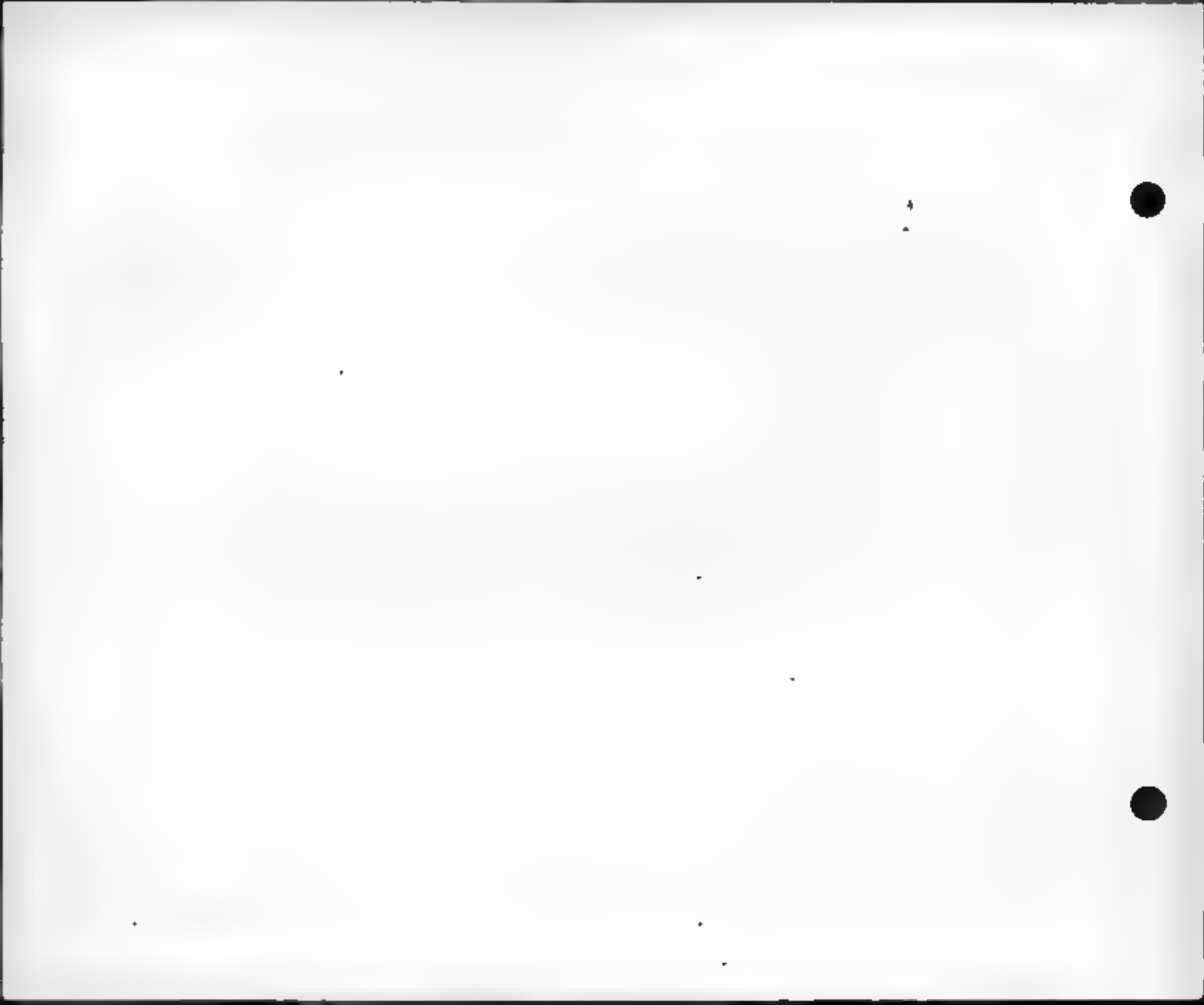
27833

07815

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Main Street</u>		d. STREET ADDRESS <u>75 Main Street</u>	
3 NAME OF DECEASED Type or print <u>First</u> <u>La</u> <u>Middle</u> <u>U.</u> <u>Last</u> <u>Mathias</u>		4 DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>Female</u>		6 COLOR OR RACE <u>white</u>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>June 20, 1887</u>		9 AGE (In years) <u>78</u> IF UNDER 1 YEAR <u>78</u> IF UNDER 24 HR. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Md.</u>	
11. FATHER'S NAME <u>George E. Ducker</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>Mary E. Lunkner</u>		14. SOCIAL SECURITY NO. <u>412-33-1332</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. INFORMANT <u>Mr. John H. Ducker</u> <u>Baltimore, Md.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>Generalized Carcinomatosis</u> DUE TO <u>Reticulum cell sarcoma</u> Conditions, if any, which gave rise to immediate cause or stating the underlying cause last: <u>none</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr</u> <u>1 1/2 yr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOT BY MEDICAL EXAMINER <u>none</u>	
20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item b		20c. TIME OF INJURY Month, Day Year <u>none</u>	
20d. INJURY OCCURRED <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>none</u>	
20f. CITY or town <u>Reisterstown, Md.</u>		20g. COUNTY <u>Balto.</u>	
21. I certify that (Name of physician) attended the deceased from <u>8-22-47</u> to <u>6-3-67</u> that (Name of physician) saw the deceased alive on <u>5-15-67</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>D. D. Caples</u>		22b. DATE SIGNED <u>6-5-67</u>	
22c. PHYSICIAN'S NAME <u>D. D. Caples, M. D.</u>		22d. ADDRESS <u>6 Hanover Rd., Reisterstown, Md.</u>	
23a. BURIAL OR CREMATION <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran cemetery</u>		23d. LOCATION (City, town or county) <u>Reisterstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eune & Sons</u>		25. ADDRESS <u>Reisterstown, Md.</u>	
26. REGISTRATION NO. <u>6-5-67</u>		27. SIGNATURE <u>Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and show it to the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

27835 27017

1 PLACE OF DEATH
 a. COUNTY Baltimore MARYLAND
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
 c. LENGTH OF STAY IN ID 6 weeks
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home in the Pines
 e. STREET ADDRESS 308 Fugleside Ave
 f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2 USUAL RESIDENCE (where deceased lived, 1 Institution, Residence before admission)
 a. STATE Ind b. COUNTY Baltimore
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
 d. STREET ADDRESS 308 Fugleside Ave
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) JAMES First A. Middle McCARON Last McCARON
 DATE OF DEATH 6-15 1967
 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 9-2-85 9. AGE (in years, months, days, hours, min.) 81 yrs
 10. MARRIED ☒ WIDOWED ☐ DIVORCED ☐

11. BIRTHPLACE (County & State, or foreign country) MD 12. CITIZEN OF WHAT COUNTRY? USA
 13. FATHER'S NAME James McCarron 14. MOTHER'S MAIDEN NAME Katharine
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO 170601 0328 17. INFORMANT Wm. Wm. Muller Address 7825 Arbor Hl
 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction
 (b) Arteriosclerotic Cardio-Vascular Disease
 (c) 15 yrs
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 yrs
 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.
 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 5-1- 1967 to 6-15- 1967, that (I) (we) last saw the deceased alive on 6-13 1967 and that death occurred at 1:30 PM, from the causes and on the date stated above.
 22a. SIGNATURE Wm. R. Gallagher 22b. DATE SIGNED 6-15-67
 22c. PHYSICIAN'S NAME (Type) Wm. R. Gallagher 22d. ADDRESS 6269 Funderick Ave. Balt. 21228 Md
 23a. BURIAL, CREMATION, or other disposal (Specify) Burial 23b. DATE THEREOF 6-17-67 23c. NAME OF CEMETERY OR CREMATORY New Cathedral 23d. LOCATION (City or town or county) (State) Baltimore Md
 24. FUNERAL DIRECTOR John J. Curran & Son Inc 25. REC'D BY REC'S OFF. Charles Judge 26. REC'D BY REC'S OFF. Charles Judge
 JUN 19 1967



MD. A. 5 4
25M 67

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 or page 3 should be detached to use as the burial transit permit. Then please remove the burial transit permit from the certificate and send it to the funeral home. The certificate should be filed with the State Dept. of Health prior to burial, cremation or removal, and a copy sent within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07836

CERTIFICATE OF DEATH

07013

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND b CITY OR TOWN IF outside corporate limits, write RURAL and give nearest town <u>TOWSON</u> LENGTH OF STAY <u>2 months</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CITY</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <u>21202</u>	
3 NAME OF DECEASED (Type in print) First Middle Last <u>ANN JUNIAN ANN MCLARTHY</u>		4 DATE OF DEATH Month Day Year <u>JUNE 30 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>CAU</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month Day Year <u>5/27/1899</u> <u>68</u> YES
9a USUAL OCCUPATION (Give kind of work done during most of working life) <u>HW</u>		9b KIND OF BUSINESS OR INDUSTRY <u>none</u>	
10 BIRTHPLACE (Country & State or foreign country) <u>BALTO MD</u>		11 COUNTRY OF WHA COUNTRY <u>USA</u>	
12 FATHER'S NAME <u>Francis Quinnlan (Dec)</u>		13 MOTHER'S MAIDEN NAME <u>Carlisle</u>	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		15 SOCIAL SECURITY NO. <u>215-10-7613</u>	
16 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause & stating the underlying cause lost b) <u>Carcinoma of the head of the pancreas</u> DUE TO c)		17 INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u> <u>Months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE (CONDITION GIVEN IN PART I) <u>NO</u>			
20a a) DEATH WAS UNDERLYING: <input type="checkbox"/> b) CONTRIBUTING: <input type="checkbox"/> c) BOTH: <input type="checkbox"/> IF EITHER NOTIFY MEDICAL EXAMINER		20b DEATH, HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 8)	
20c TIME OF INJURY Month Day Year Hour: min <u>pm</u> <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, other bldg, etc.)	20f If in town, county, state
21 certify that the hospital attended the deceased from <u>4/26</u> 19 <u>67</u> to <u>6/30</u> 19 <u>67</u> that we last saw the deceased alive on <u>6/30</u> 19 <u>67</u> and that death occurred at <u>9:40 PM</u> from causes and on the date stated above			
22a SIGNATURE <u>Daryl A Bruce</u>		22b DATE <u>6/30/67</u>	
22c PHYSICIAN'S NAME Type <u>D.A. BRUCE</u>		22d ADDRESS <u>C.D.M.C</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE OF <u>7/3/67</u>	23c NAME OF CEMETERY OR REMATORY <u>Western Cemetery</u>	23d LOCATION (City or town, county, state) <u>Balto, City, Md.</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</u>		25a REGISTRATION DATE <u>JUL 1 1967</u>	25b REGISTRAR SIGNATURE <u>Charles Judge</u>



TO HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR. A is this certificate has been signed by the attending physician and is to be filed in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health. Page 4 should be filed with the State Department of Health.

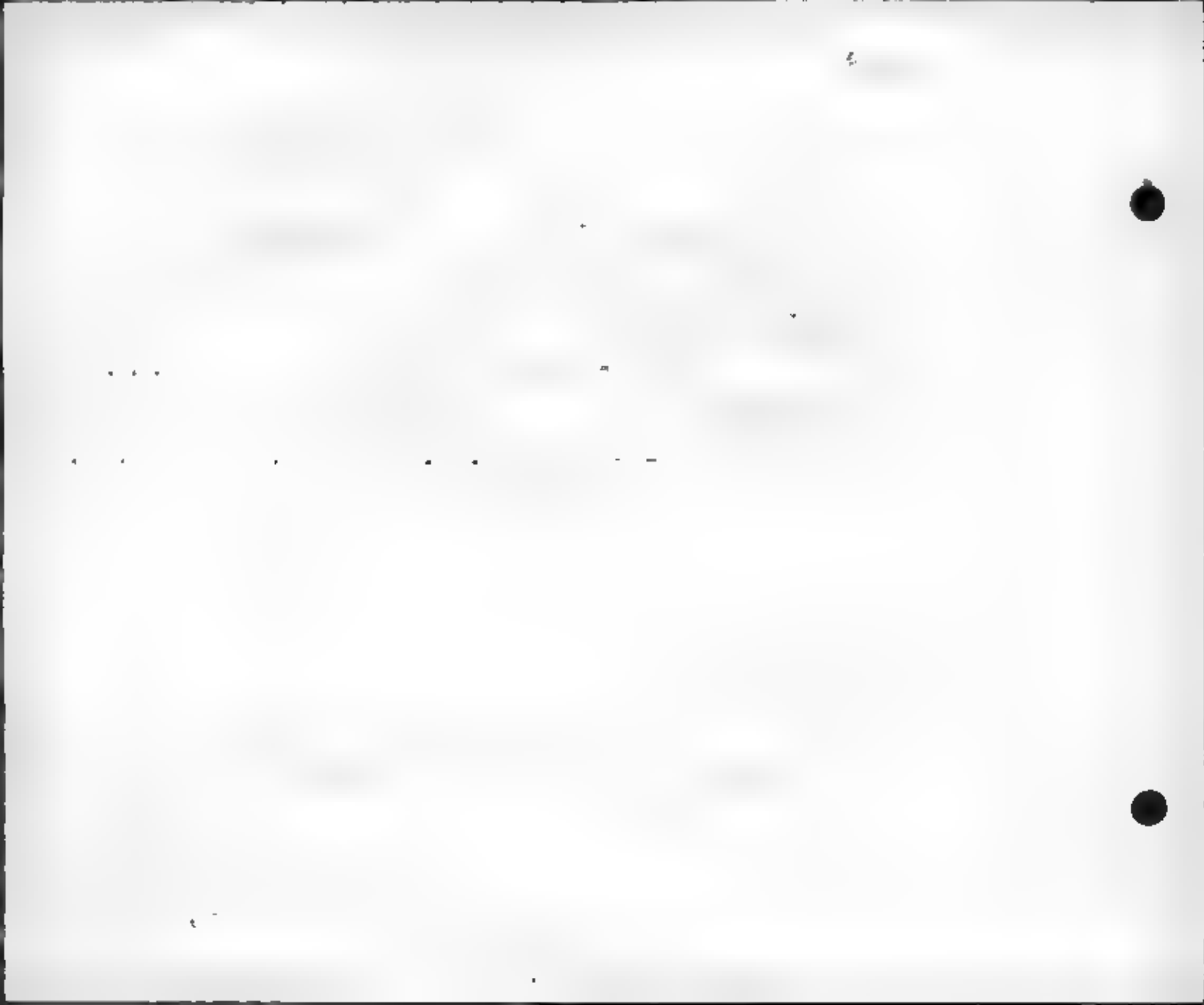
VA 5-5-64
 25M

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 30 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07837

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Fort Howard c STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e STREET ADDRESS 540 East 22nd Street	
f NAME OF DECEASED Type of print JOHN BENNIE MC INTYRE		4 DATE OF DEATH Month JUNE Day 4 Year 19 67	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/7/85
9a EDUCATION (If not known, state work done during most of working life, even if retired) Cook		9b AGE 82 years birthday yes	
10a KIND OF BUSINESS OR INDUSTRY Private Family		10b BIRTHPLACE (county & State or foreign country) Sanford, Florida	
11 FATHER NAME Robert McIntyre		12 MOTHER'S MAIDEN NAME Sallie Evans	
13 WAS DECEASED EVER IN ARMED FORCES (If yes, give year or dates of service) Yes		14 SOCIAL SECURITY NO 213-12-25-52	
15 INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md.		16 ADDRESS Clin. Rec. VA Hospital, Fort Howard, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION (b) PULMONARY EMBOLISM (c) THROMBI LEFT ATRICLE DUL TO ARTERIOCLEROTIC HEART DISEASE		INTERVAL BETWEEN DEATH AND RECORDING RECENT RECENT YEARS	
PART II: OTHER SIGNIFICANT CONDITIONS (Do not include conditions not related to the terminal disease. Condition given in Part I.) BENIGN PROSTATIC HYPERTROPHY		19a INVADED BY CANCER YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a TIME OF INJURY Month, Day, Year Month May Day 24 Year 19 67		20b PLACE OF INJURY Home or factory street, office bldg, etc. VA HOSPITAL, FORT HOWARD, MARYLAND	
21 I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from May 24 19 67 to June 4 19 67 and the death occurred on June 4 19 67 from causes and on the date stated above.		22a SIGNATURE George Kudas M.D. 22b PHYSICIAN'S NAME Type GEORGE KUDAS, M. D.	
23a BURIAL INFORMATION (Specify) Burial		23b DATE OF BURIAL 6-8-67	
24a NAME OF CEMETERY Baltimore National Cemetery		24b CITY OR TOWN Baltimore, Maryland	
25a NAME OF FUNERAL HOME Elroy Wilson Funeral Home		25b CITY OR TOWN Baltimore, Maryland	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

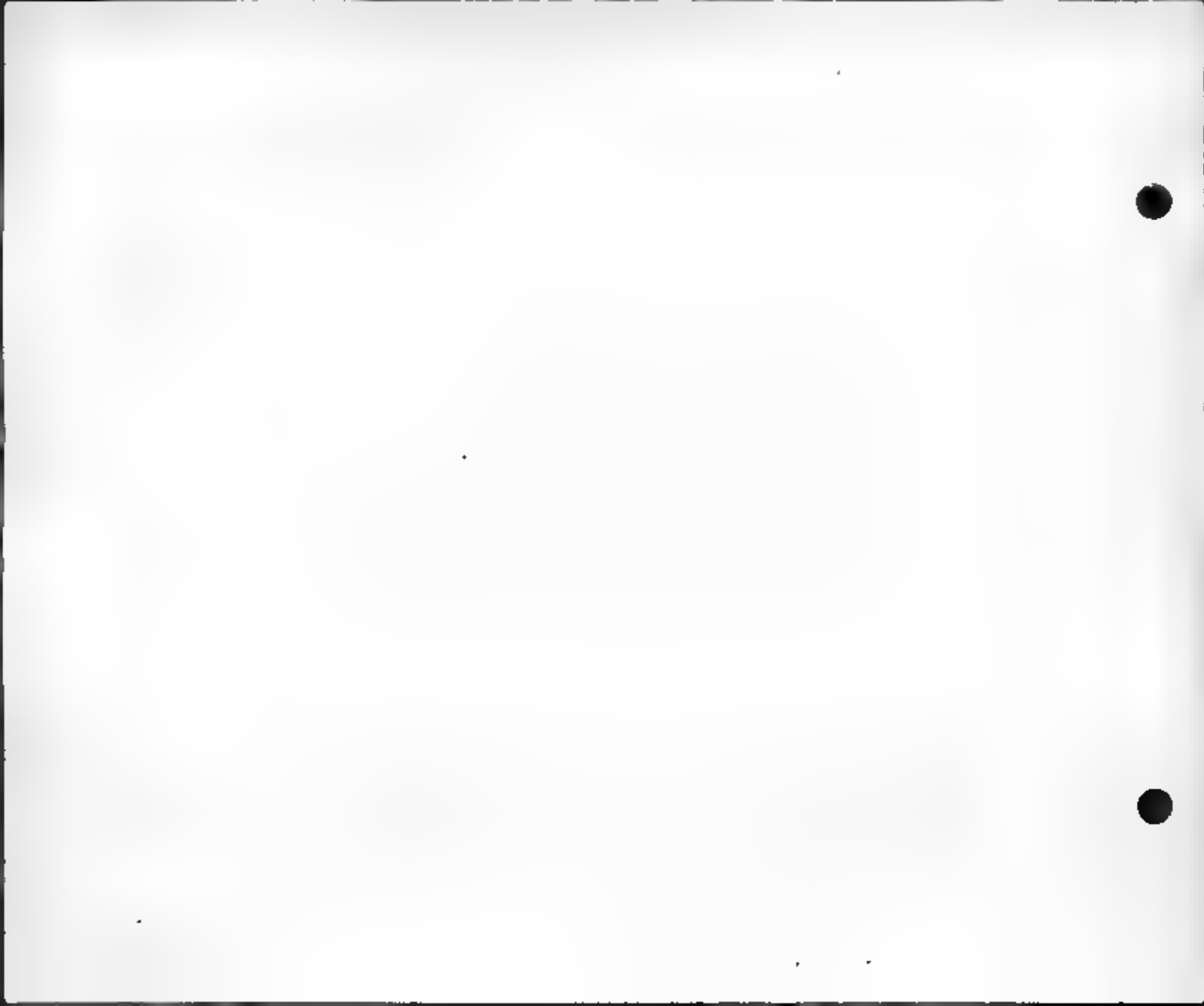
07838

CERTIFICATE OF DEATH

1967 30

PLACE OF DEATH a. <u>Baltimore</u>		USUAL RESIDENCE (where deceased lived if institution. Residence before admission) a. <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN b. <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTE (if not in hospital, give street address) <u>St Joseph Hospital</u>		e. STREET ADDRESS <u>2813 Alden Rd.</u>	
1. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas H. McManus</u>		4. DATE OF DEATH Month Day Year <u>6 7 1967</u>	
SIX <u>Male</u>	5. COLOR OR RACE <u>White</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/1878</u>
9. AGE in years at birthday, yrs <u>88</u>		10. UNDER 1 YEAR Months Day Hour Min <u>7 2 0 0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work-week over 12 retired) <u>Retired Police</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Maryland</u>	
13. FATHER'S NAME <u>Francis Patrick McManus</u>		14. MOTHER'S MAIDEN NAME <u>Alice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-1347</u>	
17. INFORMANT <u>Mr. W. Wagner</u>		Address <u>(Same)</u>	
B. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4300</u> DUE TO Congestive heart failure Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic heart disease</u> DUE TO c.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) <u>Adams-Stokes syndrome</u>		9. WA. AC. EPSPY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. IDENTIFY WAS UNDERLYING CAUSE OF DEATH (IF EITHER NOTIFY MEDIA, EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>9</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. CITY or town (County) (State) <u>Baltimore, Md.</u>
21. I certify that (this hospital) attended the deceased from <u>6/6/1967</u> to <u>6/7/1967</u> that (we last saw the deceased alive on <u>6/7/1967</u> and that death occurred at <u>3:30p</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence F. Misanik, M.D.</u>		22b. DATE SIGNED <u>June 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence F. Misanik, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>	
23a. BURIAL OR CREMATION <u>Burial</u>	23b. DATE THEREOF <u>6/12/67.</u>	23c. NAME OF METERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban paper, Pages 1 and 2, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, and 123, and 124, and 125, and 126, and 127, and 128, and 129, and 130, and 131, and 132, and 133, and 134, and 135, and 136, and 137, and 138, and 139, and 140, and 141, and 142, and 143, and 144, and 145, and 146, and 147, and 148, and 149, and 150, and 151, and 152, and 153, and 154, and 155, and 156, and 157, and 158, and 159, and 160, and 161, and 162, and 163, and 164, and 165, and 166, and 167, and 168, and 169, and 170, and 171, and 172, and 173, and 174, and 175, and 176, and 177, and 178, and 179, and 180, and 181, and 182, and 183, and 184, and 185, and 186, and 187, and 188, and 189, and 190, and 191, and 192, and 193, and 194, and 195, and 196, and 197, and 198, and 199, and 200, and 201, and 202, and 203, and 204, and 205, and 206, and 207, and 208, and 209, and 210, and 211, and 212, and 213, and 214, and 215, and 216, and 217, and 218, and 219, and 220, and 221, and 222, and 223, and 224, and 225, and 226, and 227, and 228, and 229, and 230, and 231, and 232, and 233, and 234, and 235, and 236, and 237, and 238, and 239, and 240, and 241, and 242, and 243, and 244, and 245, and 246, and 247, and 248, and 249, and 250, and 251, and 252, and 253, and 254, and 255, and 256, and 257, and 258, and 259, and 260, and 261, and 262, and 263, and 264, and 265, and 266, and 267, and 268, and 269, and 270, and 271, and 272, and 273, and 274, and 275, and 276, and 277, and 278, and 279, and 280, and 281, and 282, and 283, and 284, and 285, and 286, and 287, and 288, and 289, and 290, and 291, and 292, and 293, and 294, and 295, and 296, and 297, and 298, and 299, and 300, and 301, and 302, and 303, and 304, and 305, and 306, and 307, and 308, and 309, and 310, and 311, and 312, and 313, and 314, and 315, and 316, and 317, and 318, and 319, and 320, and 321, and 322, and 323, and 324, and 325, and 326, and 327, and 328, and 329, and 330, and 331, and 332, and 333, and 334, and 335, and 336, and 337, and 338, and 339, and 340, and 341, and 342, and 343, and 344, and 345, and 346, and 347, and 348, and 349, and 350, and 351, and 352, and 353, and 354, and 355, and 356, and 357, and 358, and 359, and 360, and 361, and 362, and 363, and 364, and 365, and 366, and 367, and 368, and 369, and 370, and 371, and 372, and 373, and 374, and 375, and 376, and 377, and 378, and 379, and 380, and 381, and 382, and 383, and 384, and 385, and 386, and 387, and 388, and 389, and 390, and 391, and 392, and 393, and 394, and 395, and 396, and 397, and 398, and 399, and 400, and 401, and 402, and 403, and 404, and 405, and 406, and 407, and 408, and 409, and 410, and 411, and 412, and 413, and 414, and 415, and 416, and 417, and 418, and 419, and 420, and 421, and 422, and 423, and 424, and 425, and 426, and 427, and 428, and 429, and 430, and 431, and 432, and 433, and 434, and 435, and 436, and 437, and 438, and 439, and 440, and 441, and 442, and 443, and 444, and 445, and 446, and 447, and 448, and 449, and 450, and 451, and 452, and 453, and 454, and 455, and 456, and 457, and 458, and 459, and 460, and 461, and 462, and 463, and 464, and 465, and 466, and 467, and 468, and 469, and 470, and 471, and 472, and 473, and 474, and 475, and 476, and 477, and 478, and 479, and 480, and 481, and 482, and 483, and 484, and 485, and 486, and 487, and 488, and 489, and 490, and 491, and 492, and 493, and 494, and 495, and 496, and 497, and 498, and 499, and 500, and 501, and 502, and 503, and 504, and 505, and 506, and 507, and 508, and 509, and 510, and 511, and 512, and 513, and 514, and 515, and 516, and 517, and 518, and 519, and 520, and 521, and 522, and 523, and 524, and 525, and 526, and 527, and 528, and 529, and 530, and 531, and 532, and 533, and 534, and 535, and 536, and 537, and 538, and 539, and 540, and 541, and 542, and 543, and 544, and 545, and 546, and 547, and 548, and 549, and 550, and 551, and 552, and 553, and 554, and 555, and 556, and 557, and 558, and 559, and 560, and 561, and 562, and 563, and 564, and 565, and 566, and 567, and 568, and 569, and 570, and 571, and 572, and 573, and 574, and 575, and 576, and 577, and 578, and 579, and 580, and 581, and 582, and 583, and 584, and 585, and 586, and 587, and 588, and 589, and 590, and 591, and 592, and 593, and 594, and 595, and 596, and 597, and 598, and 599, and 600, and 601, and 602, and 603, and 604, and 605, and 606, and 607, and 608, and 609, and 610, and 611, and 612, and 613, and 614, and 615, and 616, and 617, and 618, and 619, and 620, and 621, and 622, and 623, and 624, and 625, and 626, and 627, and 628, and 629, and 630, and 631, and 632, and 633, and 634, and 635, and 636, and 637, and 638, and 639, and 640, and 641, and 642, and 643, and 644, and 645, and 646, and 647, and 648, and 649, and 650, and 651, and 652, and 653, and 654, and 655, and 656, and 657, and 658, and 659, and 660, and 661, and 662, and 663, and 664, and 665, and 666, and 667, and 668, and 669, and 670, and 671, and 672, and 673, and 674, and 675, and 676, and 677, and 678, and 679, and 680, and 681, and 682, and 683, and 684, and 685, and 686, and 687, and 688, and 689, and 690, and 691, and 692, and 693, and 694, and 695, and 696, and 697, and 698, and 699, and 700, and 701, and 702, and 703, and 704, and 705, and 706, and 707, and 708, and 709, and 710, and 711, and 712, and 713, and 714, and 715, and 716, and 717, and 718, and 719, and 720, and 721, and 722, and 723, and 724, and 725, and 726, and 727, and 728, and 729, and 730, and 731, and 732, and 733, and 734, and 735, and 736, and 737, and 738, and 739, and 740, and 741, and 742, and 743, and 744, and 745, and 746, and 747, and 748, and 749, and 750, and 751, and 752, and 753, and 754, and 755, and 756, and 757, and 758, and 759, and 760, and 761, and 762, and 763, and 764, and 765, and 766, and 767, and 768, and 769, and 770, and 771, and 772, and 773, and 774, and 775, and 776, and 777, and 778, and 779, and 780, and 781, and 782, and 783, and 784, and 785, and 786, and 787, and 788, and 789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and jointly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the other pages and 2 should be filed with the State Dept of Health prior to burial, cremation or removal and none later than 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
77833		CERTIFICATE OF DEATH				7321			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE Where deceased lived if institution Residence before admission b. STATE Maryland b. COUNTY Baltimore				
3. SEX OR GOWN If outside corporate limits, write RURAL and give nearest town TOWSON			4. LENGTH OF STAY IN b 2 days		5. CITY OR TOWN outside corporate limits write RURAL and give nearest town TOWSON/ J. Edgar B. B.			6. IF DECEASED ON A AIRCRAFT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address: Greater Baltimore Medical Center					8. STREET ADDRESS 6701 North Charles Street			9. IF DECEASED ON A AIRCRAFT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. NAME OF DECEASED First Middle Last BABY McM LLEN					11. DATE OF DEATH Month Day Year 6 21 1967		12. IF UNDER YEAR Month Day Hour Min 2		
13. SEX Male		14. COLOR OR RACE W		15. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		16. DATE OF BIRTH 6/9/67		17. AGE in years last birthday yrs Month Day Hour Min 2	
18. USUAL OCCUPATION Give kind of work done during most of working life even if retired				19. KIND OF BUSINESS OR INDUSTRY		20. BIRTHPLACE County & State or foreign country Baltimore, Maryland		21. SEX OF WHAT U. S.	
22. FATHER'S NAME Donald Henry McMullen					23. MOTHER'S MAIDEN NAME Carol Anne O'Donnell				
24. WAS DECEASED EVER IN U. S. ARMED FORCES Yes No or unknown				25. SOCIAL SECURITY NO None		26. INFORMANT Dr. N. H. Kolsky		27. Address Greater Baltimore Medical Center	
28. CAUSE OF DEATH Enter only one cause per line for a, b, and c a. PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE is 7/13C Hyaline Membrane Disease b. DUE TO c. DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause for: 29. PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART a NO 30. a. IDENTIFY WAS UNDERLYING OR CONTRIBUTORY CAUSE OF DEATH IF PER MONEY MEDICAL EXAMINER 31. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 32. INJURY OR ILLNESS White <input type="checkbox"/> Not White <input type="checkbox"/> 33. PLACE OF INJURY Home or factory street, office bldg, etc. 34. If at home, county, state 35. I certify that (with a hospital) attended the deceased from 6/19 967 to 6/21 967 that saw the deceased alive on 6/21 967 and that death occurred at 4:24 PM from causes and on the date stated above 36. SIGNATURE John E. Adams M.D. 37. PHYSICIAN'S NAME AND ADDRESS John E. Adams, M.D. Greater Baltimore Medical Center 38. SURVIVAL REMOVAL (Specify) BURIAL 39. DATE HEREOF 6/26/67 40. NAME OF CEMETERY OR REMOVAL BALTIMORE NATIONAL 41. ADDRESS BALTIMORE, MARYLAND 42. IF BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge 43. DATE JUN 27 1967									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

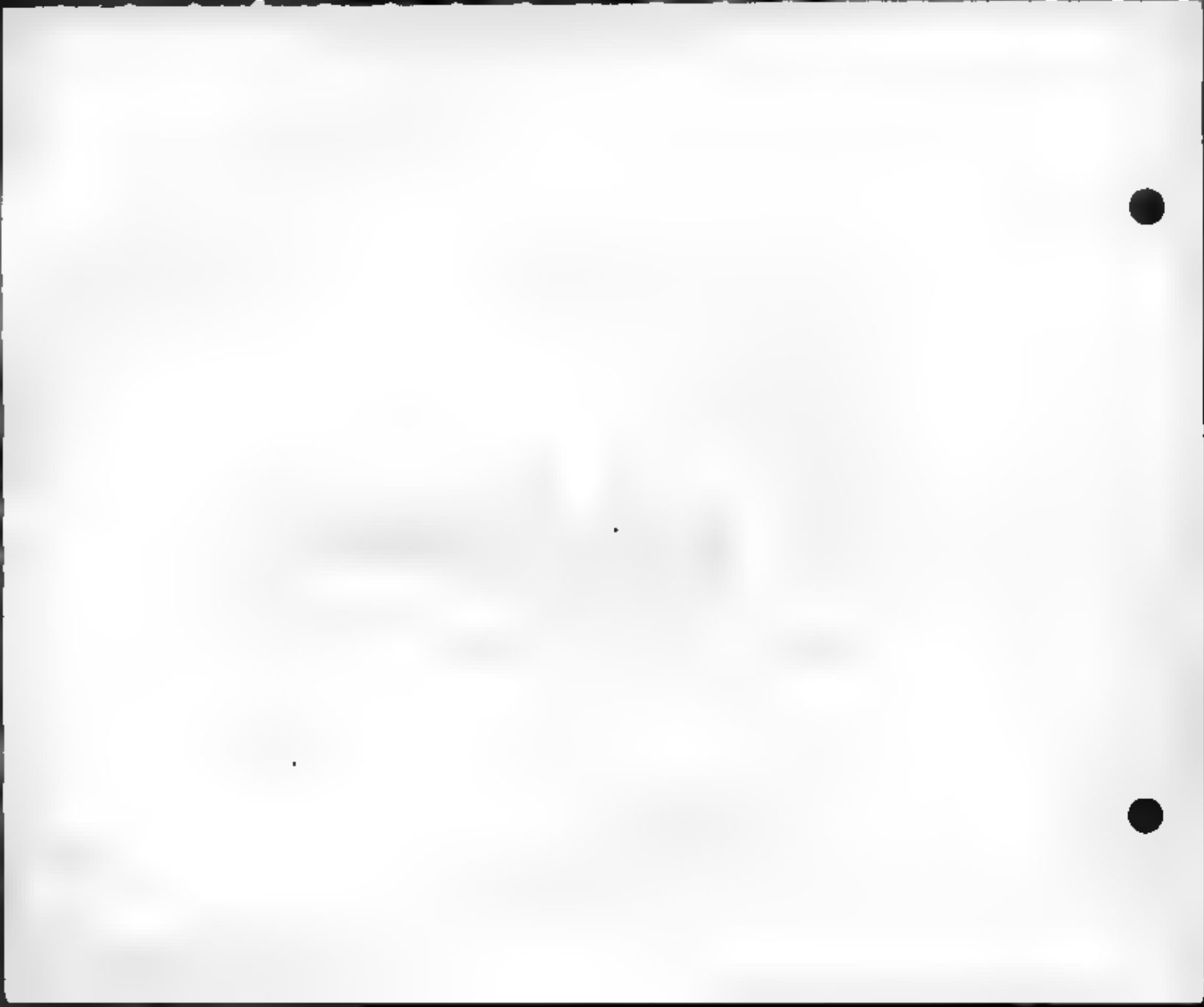
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27840

27322

1. PLACE OF DEATH a. COUNTY <u>Harford County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Harford</u>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		4. LENGTH OF STAY IN 15 <u>218</u>	
5. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>218 W. 1st St. Harford</u>		6. STREET ADDRESS <u>218 W. 1st St. Harford</u>	
7. NAME OF DECEASED (Type or print) First <u>Sam</u> Middle <u>Samuel</u> Last <u>M. Bair</u>		8. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1967</u>	
9. SEX <u>Male</u>		10. COLOR OR RACE <u>Negro</u>	
11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH <u>5-25-1898</u>	
13. AGE (In years, if UNDER 1 year, if UNDER 24 HRS. last birthday) Months <u>6</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>		14. BIRTHPLACE (State or foreign country) <u>Kennerly, S.C.</u>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		16. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>	
17. FATHER'S NAME <u>Frank M. Bair</u>		18. MOTHER'S MAIDEN NAME <u>Anna M. Bair</u>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		20. SOCIAL SECURITY NO. <u>203 100 1 100</u>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART - DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Cardiovascular Disease</u>			
PART - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Exogenous obesity</u>		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of Item 18.)	
24. TIME OF INJURY Month, Day, Year Hour <u>8</u> M. <u>00</u> P.M. <u>29</u>		25. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. <u>Home</u>	
26. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		27. CHIEF OF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. ACTUAL SIGNATURE <u>Thos C Patterson</u>		29. DATE SIGNED <u>6/7/67</u>	
30. EXAMINER'S NAME (Type) <u>Thos C Patterson, M.D.</u>		31. ADDRESS (Street, city, town, or county) <u>1700 E. 1st St. Baltimore</u>	
32. BURIAL CREMATION, 23b. DATE THEREOF <u>6-8-67</u>		33. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	
34. FUNERAL DIRECTOR <u>Harold Dyer, Jr.</u>		35. ADDRESS <u>1700 E. 1st St. Baltimore</u>	
36. REC'D BY REG. STRAR <u>17</u>		37. REC. STRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 8 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please reattach urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation or removal and, in any event, within 72 hours after death.

VA 15-4
25M 1-67

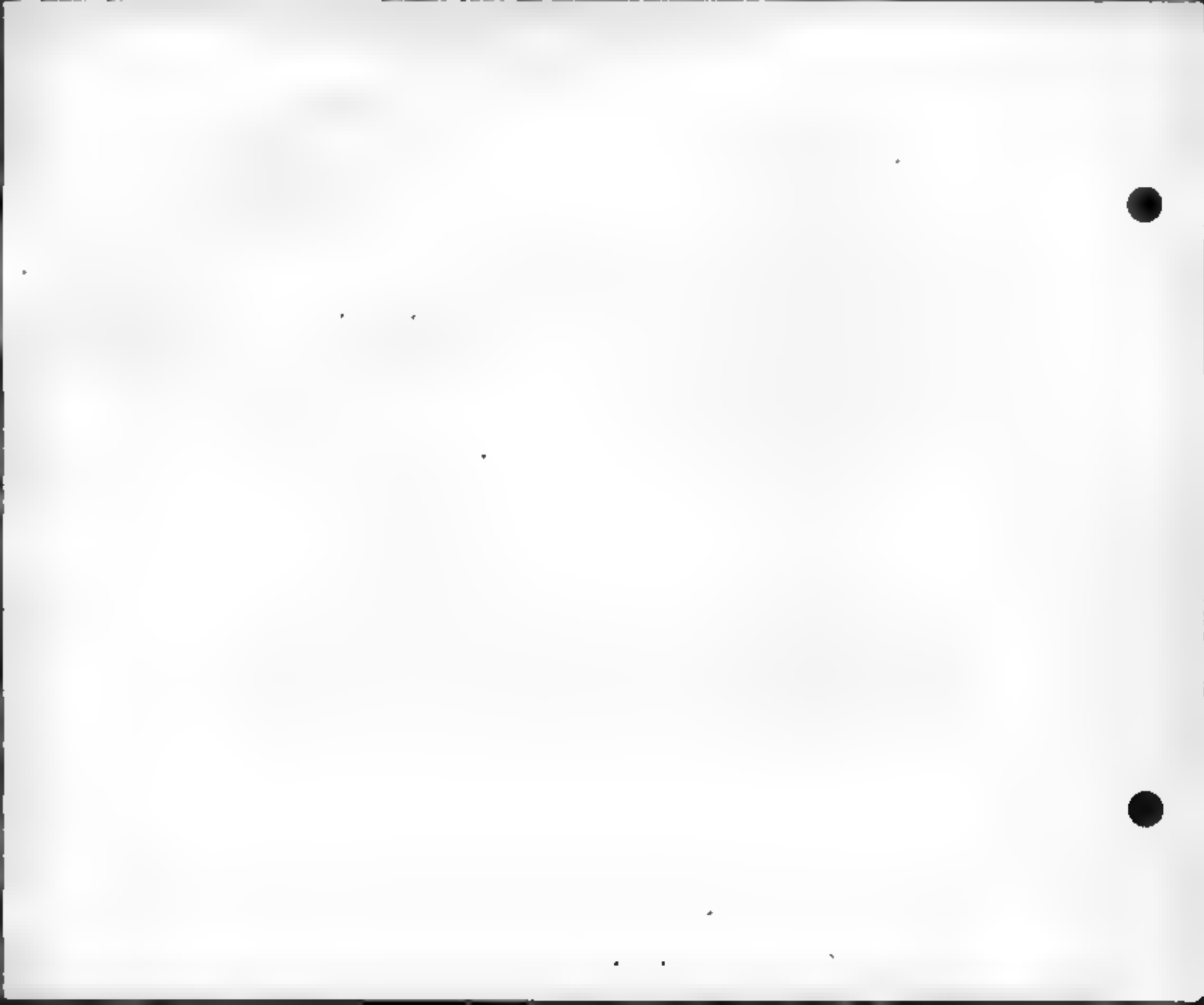
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07841

07823

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
3 NAME OF DECEASED First Middle Last ARGYLE G. METTEE		4 DATE OF DEATH Month Day Year June 29, 1967	
SEX Male	5 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH July 18, 1900.
9 AGE in years last birthday 66		10 UNDER 1 YEAR Months Days Hours 66	
11a. IS IN OCCUPATION? Give kind of work done during most of working life, even if retired. Retired Auditor		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12 FATHER'S NAME Eugene Mettee		13 MOTHER'S MAIDEN NAME Agatha Wiessner	
14 WAS DECEASED EVER IN ARMED FORCES? (Yes) Unk. No (If yes, give year or dates of service)		15 SOCIAL SECURITY NO. Unk.	
16 INFORMANT Mrs. Mabel L. Mettee		17 ADDRESS (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Disease 4201 DUE TO Conditions (any which gave rise to immediate cause (a), stating the underlying cause last) DUE TO (b) DUE TO (c)		19 INTERVAL BETWEEN ONSET AND DEATH 17 hrs.	
PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR I None			
20a. DECEASED UNDER (INC.) OR CONTRAINDICATION CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a or Part II of item B)	
20c. TIME OF INJURY Month Day Year Hour AM PM 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.,	20f. CITY or town County State
21 I certify that (1) this hospital attended the deceased from August 1966 to June 29, 1967 that (2) I saw the deceased alive on June 29, 1967 and that death occurred on June 29, 1967 from causes and on the date stated above			
22a. SIGNATURE Ray M. Zimmerman		22b. PHYSICIAN'S NAME (Typed) Ray M. Zimmerman M.D.	
23a. BURIAL CREMATION REMOVAL Burial		23b. DATE OF BURIAL 7/3/67	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25 REGISTRATION Elkridge, Md.	
26 DATE JUN 30 1967		27 SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial. Cremation or removal of the body must be completed within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. LENGTH OF STAY IN b. 14 mo.		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside separate limits, write RURAL and give nearest town) Baltimore 21234	
3 NAME OF HOSPITAL, OR IN <input type="checkbox"/> ON <input type="checkbox"/> If not in hospital, give street address 4111 Campbell Rd. 21207		d. STREET ADDRESS 2002 Pickering Dr. Apt. D	
4 NAME OF DECEASED (Type in print) Core Ma Miller		5 DATE OF DEATH Month June Day 22 Year 1967	
6 SEX Female	7 COLOR OR RACE White	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 DATE OF BIRTH 8/4/81
10 OCCUPATION (Give kind of work done during most of working life, even if retired) Store		11 AGE in years 86 (Type in full) Month 14 Day 22 Year 1967	
12 FATHER'S NAME John T. Rollins		13 MOTHER'S M maiden name Mary K. Krebs	
14 SOCIAL SECURITY NO. 214-14-5003-A		15 INFORMANT Paul A. Tower 6111 Campbell Rd. 21207	
16 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) 1. Cerebral Vascular Accident b. DUE TO 4. Arterio-sclerotic Heart Disease c. DUE TO 5. Generalized Arterio-sclerosis		17 INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs	
18 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis		19 WAS A TOXIC PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AL. DEPT. WAS UNDERRIVING <input type="checkbox"/> OR IN RIGIDITY <input type="checkbox"/> ADJ. OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)	
21. TIME OF INJURY Month Day Year Hour min. 19		22. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from 4/17 19 66 to June 22 19 67 that I saw the deceased alive on 6/19 19 67 and that death occurred at 4:00 PM from causes and on the date stated above.			
26a. SIGNATURE Earl L. Chambers		26b. DATE SIGNED 6/22/67	
27a. PHYSICIAN'S NAME (Type) Earl L. Chambers		27b. ADDRESS 4108 Liberty Rd. Baltimore, Md.	
28a. BURIAL, CREMATION, REMOVAL (Specify) burial		28b. DATE THEREOF 6-26-1967	
29a. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		29b. LOCATION (City or town) (County) (State) Baltimore Md.	
30. FUNERAL DIRECTOR James H. ...		31. RECEIVED BY REGISTRAR June 26 1967	
32. REGISTRAR'S SIGNATURE James H. ...		33. DATE June 26 1967	

16
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and notify event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07843 57023

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY N ID
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 19 S MORERICK RD.

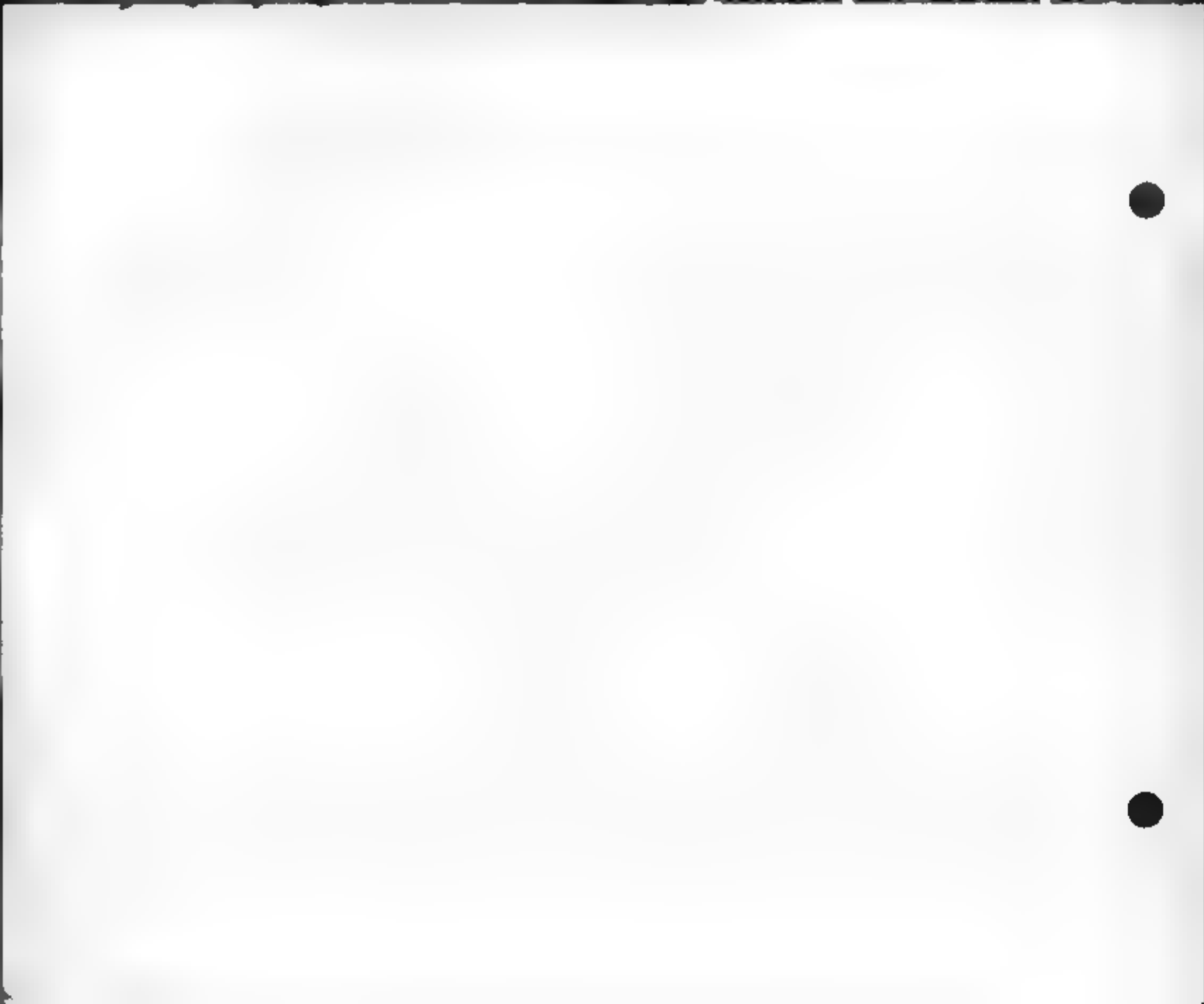
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE
d. STREET ADDRESS 19 S MORERICK RD.

3. NAME OF DECEASED (Type or print) DELORES M MILLER
4. DATE OF DEATH JUNE 3 1967
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH APRIL 1-1906 9. AGE in years, 1st birthday 61 yrs Months 2 Days 12 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE MOTHER 11. BIRTHPLACE (County & State, or foreign country) ST. AGNES HOSPITAL BALTIMORE MD 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME EDWARD BALL 14. MOTHER'S MAIDEN NAME EMILY FETHE
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 218-32-9393 17. INFORMANT MRS. ANNE KROFFELDER Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHOLESTEROL
DUE TO (b) arteriosclerosis
DUE TO (c) congestive heart failure
PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos. 4 years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTR BUT NG CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day Year June 1 1967 20d. INJURY OCCURRED ☐ While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BALTIMORE MD 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1 1967 to June 3 1967, that (I) (we) last saw the deceased alive on June 1 1967, and that death occurred at 4:00 P.M. from the cause and on the date stated above.
22a. SIGNATURE George A. Farley M.D. 22b. DATE SIGNED 6/5/67
22c. PHYSICIAN'S NAME (Type) GEORGE A. FARLEY 22d. ADDRESS 6601 FEDERICK AVE
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL 23b. DATE THEREOF JUNE 5 1967 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE MD 23d. LOCAT ON (City town or county) (State)
24. FUNERAL DIRECTOR GEORGE A. FARLEY 25a. REC'D BY REG. STRAR JUN 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN OR outside corporate limits, write RURAL and give nearest town Rural-White Hall
c. LENGTH OF STAY IN MD 25 yrs
d. NAME OF HOSPITAL OR INST. (if not in hospital, give street address) Bernoudy Rd.

2. USUAL RESIDENCE (Where deceased lived, if not before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN OR outside corporate limits, write RURAL and give nearest town Rural-White Hall
d. STREET ADDRESS Bernoudy Rd.

3. NAME OF DECEASED (Type or print) Edna Mae Miller
4. DATE OF DEATH June 21 1967
5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Aug. 14, 1901 9. AGE in years 63 10. UNDER 1 YEAR IF "NO" 24 HRS Months Days Hours Min

11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 12. KIND OF BUSINESS OR INDUSTRY Box factory 13. BIRTHPLACE (State or foreign country) Baltimore Co, Md U.S.A. 14. TOWN OF WHAT COUNTRY

15. FATHER'S NAME Unknown 16. MOTHER'S MAIDEN NAME Unknown

17. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No 18. SOCIAL SECURITY NO. 219-01-4008 19. INFORMANT Mrs Edna Miller, White Hall, Md. Address

20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cerebral thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b).
DUE TO (c).
PART II. OTHER SIGN OF CAUSE OF DEATH CONTRARY TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

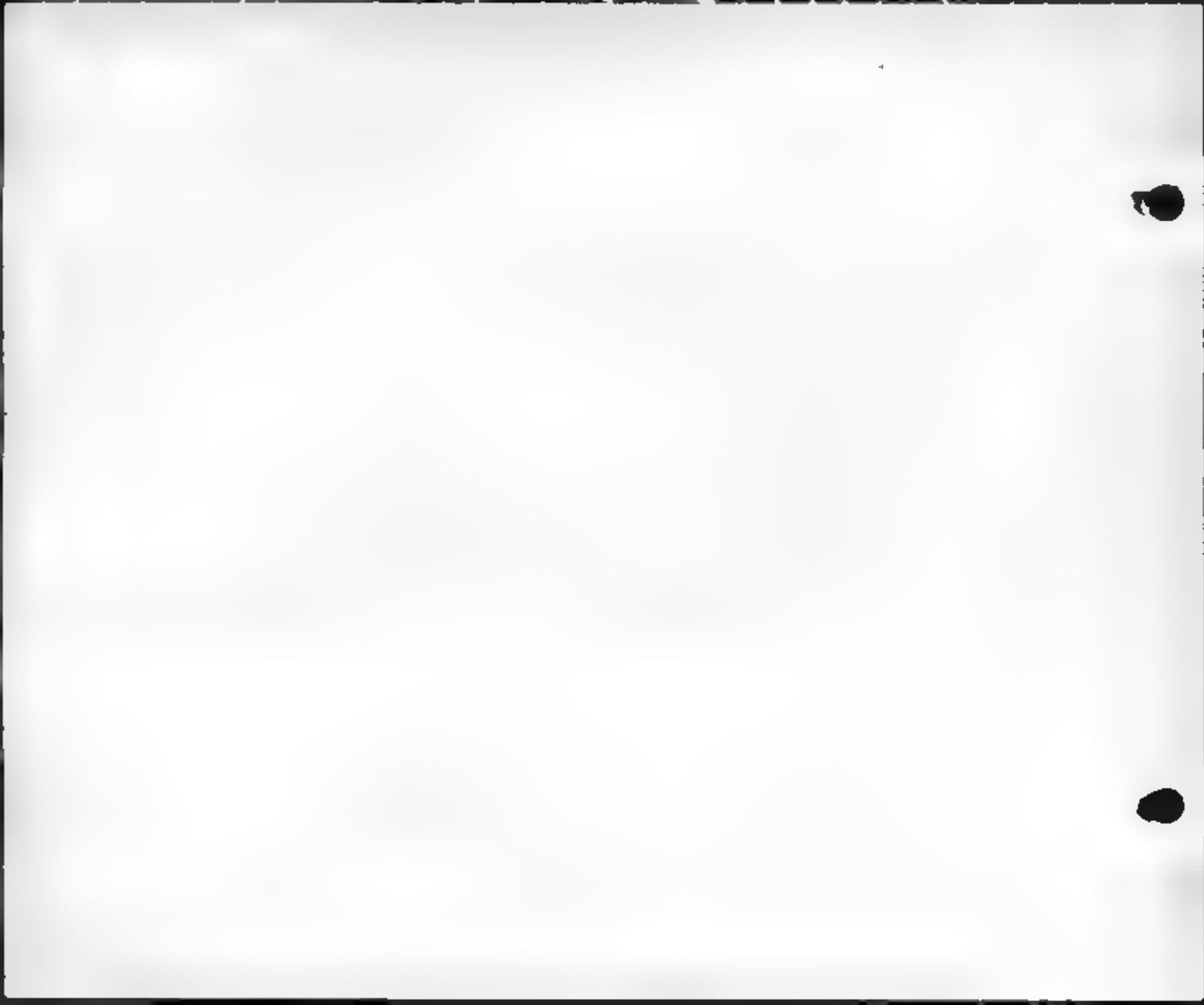
21. EXTERNAL CAUSE WAS PR. MARY OR CON. R BUT NG ☐ 22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
23. TIME OF INJURY Month Day Year 24. INJURY OCCURRED 25. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.
26. (City or town) (County) (State)

27. I certify that I took charge of the remains described above, held an Autopsy ☐, inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

28. ACTUAL SIGNATURE C. M. Francis M.D. 29. ASSISTANT MEDICAL EXAMINER ☐ 30. DEPUTY MEDICAL EXAMINER ☒ 31. DATE SIGNED 6/21/67
EXAMINER'S NAME (Type) A. M. I. Francis Address (Street, city, town or county) (State)

32. BURIAL, CREMATION, or REMOVAL Burial 33. DATE THEREOF June 26, 1967 34. NAME OF CEMETERY OR CREMATORY Freeland Cemetery 35. LOCATION (City, town or county) (State) Freeland, Md.

36. FUNERAL DIRECTOR Spencer Hartenstein, New Freedom, Pa. ADDRESS 1211 N. 1st St., New Freedom, Pa. 37. DATE JUN 26 1967 38. SIGNATURE Charles J. J. J.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: The examiner should be executed with a 24-hour certificate of death. The necessary please execute the certificate writing the word pending in pencil on page 8. Give Pages 1 & 2 to the funeral director. The State Department of Health prior to burial. The State Department of Health prior to burial.

TO FUNERAL DIRECTOR: The State Department of Health prior to burial. The State Department of Health prior to burial.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07845

07527

PLACE OF DEATH
COUNTY

Baltimore

USUAL RESIDENCE IN

Baltimore

Baldwin (Arad)

Life

Baldwin, Md.

St. Joseph's Hospital

Ansari Drive Baldwin P.O.

NAME OF
DECEASED

George H. Miller

DATE
OF
DEATH

6 8 67

Male

White

Married

NEWLY MARRIED

DA

9-2-1903

63

PA IN

PA IN

BIRNHA

U.S.A.

Farmer

Own farm

Baltimore Co. Maryland

OTHER NAME

Henry J. Miller

Mary Landenklos

YES OR UNKNOWN

212-38-1133

INFORMANT

21013

Mrs Henry J. Miller Ansari Drive Baldwin

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

Fractured Left Femur 5 1/2 hrs
Fractured Left Femur 5 1/2 hrs
Fractured Left Femur 5 1/2 hrs

CONDITION GIVEN IN PART 10

Fractured Left Femur
Fell on floor in own home
Fell on floor in own home

2 I certify that the death was caused by natural causes

ACTUAL
SIGNATURE

CHARLES F. O'DONNELL, M.D.

DATE SIGNED

6/8/67

NAME OF

6-10-1967

St. John's Luth. Cemetery

Sweet Air

Md.

NAME OF

6-10-1967

St. John's Luth. Cemetery

Sweet Air

Md.

NAME OF

6-10-1967

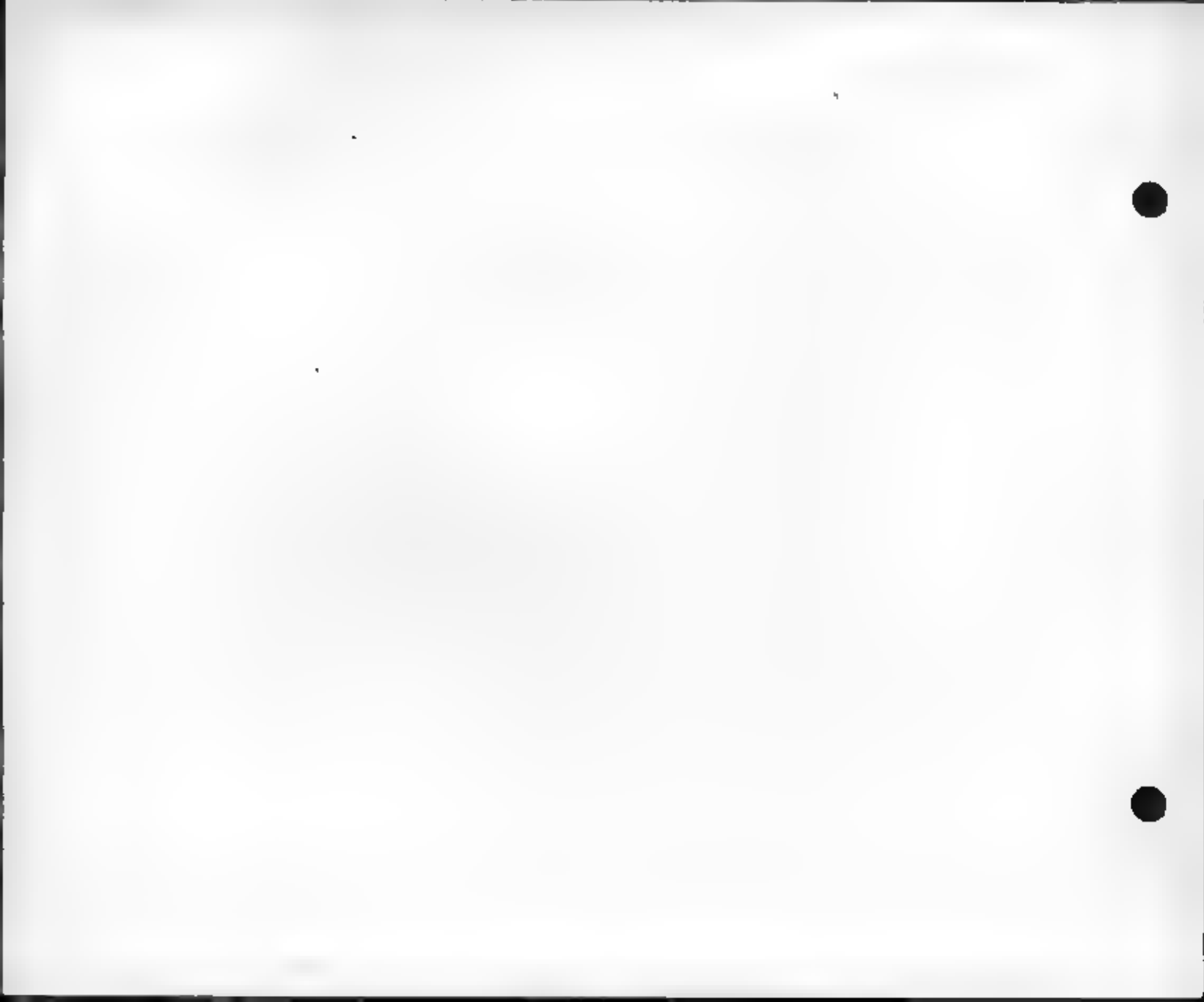
St. John's Luth. Cemetery

Sweet Air

Md.

JUN 12 1967

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. The funeral director should remove carbon papers and should be filed with the State Dept. of Health prior to burial, cremation or entombment in any event within 72 hours after death.

VS A 4
25A 12

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07846

07523

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore Towson c LENGTH OF STAY in b Month		2 USUAL RESIDENCE Where deceased lived at usual residence in having prior year a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cockeysville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		d STREET ADDRESS Ashland Road (250)	
3 NAME OF DECEASED Type of birth First Middle Last MARION A MILLER		4 DATE OF DEATH Month Day Year June 9 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-20-10 a AGE in years 56 b MONTH 5 c DAY 5 d MIN 0
10a IS IN OCCUPATION (Give kind of work done during most of working life even if retired) Security Guard		10b KIND OF BUSINESS OR INDUSTRY Guard	
3 a HER NAME Charles Miller		4 MOTHER'S MAIDEN NAME Sarah	
5 WA DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes W W. Two		10 SOCIAL SECURITY NO 212-1+ 1498	
6 CAUSE OF DEATH Enter only one cause per line for (a) (b) and (c) PART DEATH WAS CAUSED BY Myocardial infarction 4201 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO stating the underlying cause (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE (d) OTHER GIVEN IN PART II		INFORMED BY WHOM ONSET AND DURATION	
20a IF DECEASED WAS INJURED OR CONTRIBUTING CAUSE OF DEATH (If FATHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Give nature of injury in Part II or Part II a) (b) (c)	
20c TIME OF INJURY Month Day Year Hour: min: sec 19		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory street office bldg etc)		20f TIME OF INJURY (Month Day Year) (Hour: min: sec)	
2 I certify that this hospital attended the deceased from 5-9-1967 to 6-9-1967 and that death occurred at 3:50 PM from causes and on the date stated above.		20g DATE JUN 10	
21a SIGNATURE Emmo M. Gayoso, M.D.		21b DATE JUN 10 6-9-67	
22 PHYSICIAN'S NAME Type Emmo M. Gayoso, M.D.		22a ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a BURIAL CREMATION R MUYAL Society Burial	23b DATE HEREOF June 13, 1967	23c NAME OF FUNERARY OR CREMATORY Bel Air Memorial Gardens	23d LOCATION City or town County State Bel Air, Maryland
24 FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a FILED BY REGISTRAR DATE JUN 14 1967 25b REGISTRAR SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon pages 1, 2, and 3 and file with the State Dept of Health prior to burial, cremation or removal, and notify event within 72 hours after death should be filed with the State Dept of Health prior to burial, cremation or removal, and notify event within 72 hours after death.

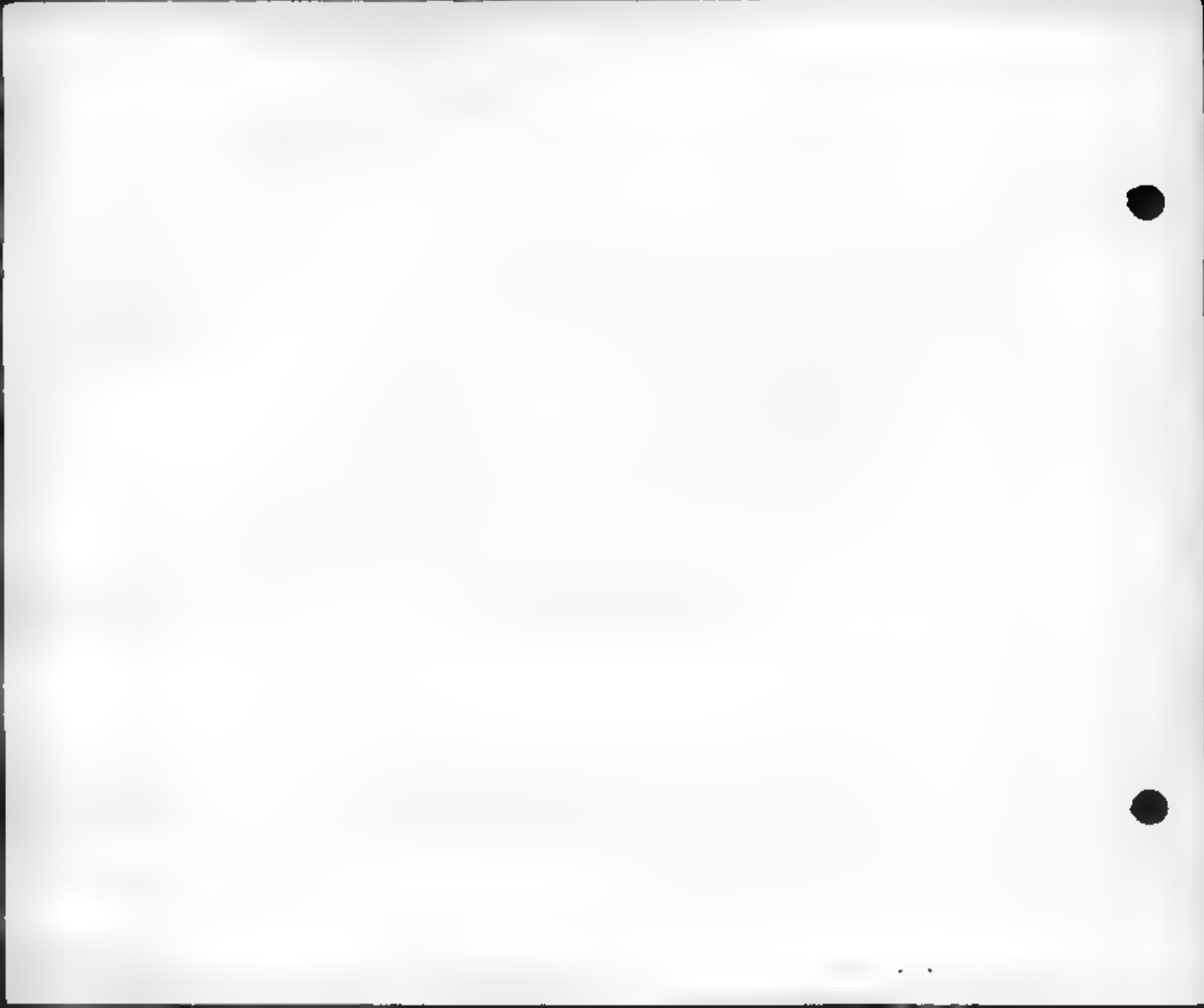
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07847

CERTIFICATE OF DEATH

07829

PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		7. USUAL RESIDENCE (Where deceased lived if inside or Residence before admission) b. STATE MARYLAND b. COUNTY ARTEA DEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ONARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS REF 3, BOX 13	
3. NAME OF DECEASED Type of person First Middle Last WILLIAM EDWARD MILLER		4. DATE OF DEATH Month Day Year JUNE 6, 1967	
5. SEX MALE 6. COLOR OR RACE NEURO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> APRIL 20, 1916		9. AGE in years last birthday 51 10. UNDER YEAR 1 11. UNDER YEAR 1 12. UNDER YEAR 1	
13. ALXICATION Give kind of work done during usual working life even if retired LABORER		14. BIRTHPLACE (State and County) ARNDT, MARYLAND	
15. FATHER'S NAME WESLEY E. MILLER		16. MOTHER'S MARDEN NAME MARY E. WOODWARD	
17. VA DECLARATION (If yes give date of service) YES		18. SOCIAL SECURITY NO 220 05 0338	
19. CAUSE OF DEATH (State only one cause per line if not one) PART I DEATH CAUSED BY IMMEDIATE CAUSE TO 15X CARCINOMA OF STOMACH		20. WITH SOLITARY LIVER METASTASIS AND BILIARY OBSTRUCTION	
21. BILIARY CIRRHOSIS AND BRONCHOPNEUMONIA		22. SIGNATURE John D. Talbert	
23. PHYSICIAN NAME JOHN D. TALBERT, M. D.		24. ADDRESS VAH FORT HOWARD, MARYLAND	
25. B. RIA REMOVAL RMO. A. SPECIFY BURIAL		26. DATE OF REMOVAL 6/10/1967	
27. NAME OF MFTERY OR REMOVAL MT. CALVERY CEMETERY		28. ADDRESS ARNOLD, MARYLAND	
29. FUNERAL DIRECTOR C.E. Hicks, 111		30. REF'D BY R GUS RAR JUN 12 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07848

07860

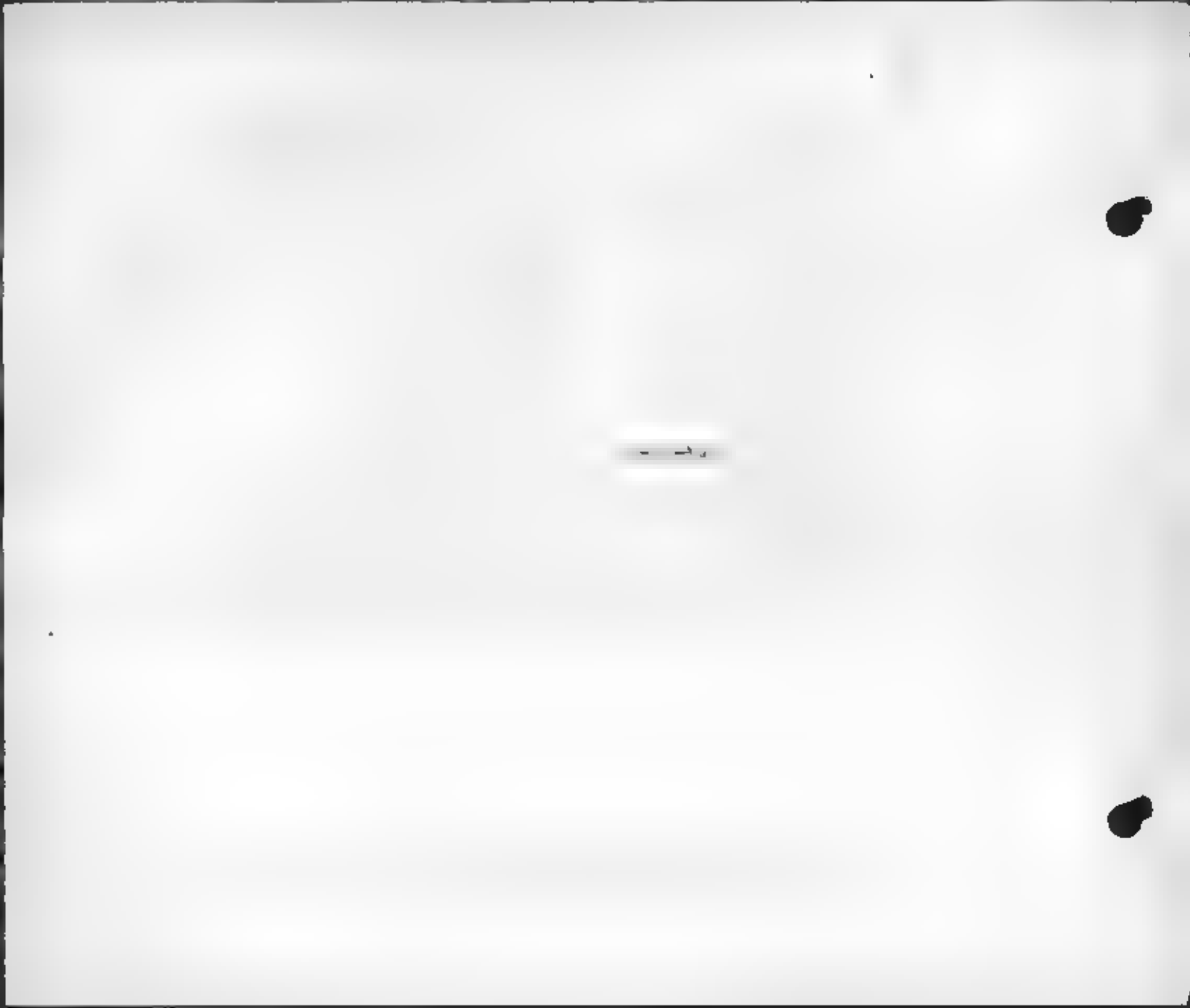
1 PLACE OF DEATH a COUNTY <u>BALTE</u> b CITY OR TOWN (in outside corporate limits write RURAL and give nearest town) <u>917 REGINA DR</u> c NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <u>BALTE 21227</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>BALTE</u> c CITY OR TOWN (in outside corporate limits write RURAL and give nearest town) <u>917 REGINA DR</u> d STREET ADDRESS <u>21227</u> e IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3 NAME OF DECEASED (Type in print) <u>HARRY FRANCIS MOORE</u> a SEX <u>M</u> b COLOR OR RACE <u>W</u> c MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> d WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> e DATE OF BIRTH <u>10/17/16</u> f AGE (in years last birthday) <u>51</u> g UNDER YEAR <u>51</u> h UNDER YEAR <u>51</u> i UNDER YEAR <u>51</u>		4 DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1967</u> 5 BIRTHPLACE (County & State or foreign country) <u>MD</u> 6 TOWN IF WHAT COUNTRY? <u>USA</u>	
7 OCCUPATION (Give kind of work done during most of working life even if retired) <u>WATER PUMPING</u> 8 KIND OF BUSINESS OR INDUSTRY <u>OWNER</u> 9 BIRTHPLACE (County & State or foreign country) <u>MD</u> 10 TOWN IF WHAT COUNTRY? <u>USA</u>		11 FATHER'S NAME <u>HARRY E MOORE</u> 12 MOTHER'S MAIDEN NAME <u>CHARLOTTE TARR</u>	
13 WAS DECEASED EVER IN ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>YES</u> 14 SOCIAL SECURITY NO. <u>215099532</u> 15 INFORMANT <u>MURLE E. MOORE</u> Address		16 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinoma, abdomen</u> DUE TO (b) <u>Carcinoma of stomach</u> Condition, if any which gave rise to immediate cause (c), stating the underlying cause last (c) <u>2 yrs</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> 19 WAS IT "SUICIDE"? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20a IDENTIFYAL UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I at item B) 20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f CITY or town 20g STATE		21 certify that this hospital attended the deceased from <u>July 2, 1965</u> to <u>June 21, 1967</u> that we last saw the deceased alive on <u>June 8, 1967</u> and that death occurred at <u>1:00 PM</u> from causes and on the date stated above	
22a SIGNATURE <u>B. J. Murphy</u> 22b PRINT NAME (Type) 22c ADDRESS		22d DATE SIGNED <u>6-22-67</u> 22e ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23 BURIAL REMOTION, REMOVAL (Type in) <u>B. R. I. A.</u> 23b DATE THEREOF <u>6/24/67</u> 23c NAME OF CEMETERY OR REMATORY <u>THE HAWKSWRIDGE</u> 23d LOCATION (City or town, county, state) <u>HOWARD CO MD</u>		24 FUNERAL DIRECTOR <u>E. S. MALINAB</u> 24b ADDRESS <u>301 FREDERICKA</u> 24c CITY <u>21228</u> 25a REC'D BY REGISTRAR <u>June 26 1967</u> 25b REGISTRAR'S SIGNATURE <u>Thos. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the hospital or funeral director, page 3 of this certificate should be detached for use as the burial permit. Then please return to the hospital or funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and should be filed with the State Dept. of Health prior to burial, cremation, or removal.



544 A

Wm. E. Dodge



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the funeral director, it should be retained for use as the basis for the death certificate. Page 3 should be retained with the State Dept. at Headquarters in Baltimore, Maryland.

TO BUREAU OF VITAL RECORDS The law requires that the death certificate be retained for use as the basis for the death certificate. Page 3 should be retained with the State Dept. at Headquarters in Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07850

CERTIFICATE OF DEATH

7:32

PLACE OF DEATH a DUNY baltimre c CITY OR TOWN if outside corporate limits write RURAL and give nearest town Catonsville d NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address SPRING GROVE STATE HOSPITAL		7 USUAL RESIDENCE (Where deceased lived a YEAR b COUNTY Maryland c CITY OR TOWN if outside corporate limits write RURAL and give nearest town Baltimore 21228 Catonsville d STREET ADDRESS 1101 Edgewood Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED Type of print First Middle Last Leard Moxley f SEX male g COLOR OR RACE white h AGE in years months days 38 58 i DATE OF DEATH June 3 1967 j MONTH YEAR IF UNDER 24 HRS Months Days Hours Min k TIME OF DEATH 11:05		10 SEX OF BIRTH July 16, 1908 11 AGE in years months days 11 58 12 COUNTRY OF BIRTH U. S.	
13 FATHER NAME William Moxley 14 MOTHER'S MAIDEN NAME Johanna Scannell		15 SOCIAL SECURITY NO 22-10-1082 16 INFORMATION Records: SPRING GROVE STATE HOSPITAL	
17 CAUSE OF DEATH Enter only one cause per line (a) (b) and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE TO 334X DUE TO Arteriosclerosis, cerebral and generalized 18 INTERVAL BETWEEN ONSET AND DEATH		19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a a) DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH b) OTHER NOTIFY MEDICAL EXAMINER 20b DISCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 20c PLACE OF INJURY (Home farm factory street office bldg etc) 20d CITY or town (County) (State)	
21 I certify that (this hospital) attended the deceased from Nov. 3 1966 to June 3 1967 that we last saw the deceased alive on June 3 1967 and that death occurred at 11:05 P.M. from causes and on the date stated above 22a SIGNATURE Stella Wachslar 22b PHYSICIAN'S NAME Type Stella Wachslar, M.D. 22c ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		23a BURIAL REMOTION Burial 23b DATE 6/8/1967 23c NAME OF CEMETERY OR REMATORY New Cathedral Cemetery Baltimore, Maryland 23d LOCATION City or town County State 23e BURIAL SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER I indicate should be executed with a 74 En's date depth t
ne en's page ex w as a phone writing the word pending in penul m 8 Give Pages 2 and 3
the when director Page 4 should be forwarded to the Chief Medical Examiner. I are along with form PMJ Page
5 may be retained for your files

VER 4.50A
04/01/01

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 30 W. PRESTON STREET BALTIMORE MARYLAND 21201

97851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

075333

PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (If deceased lived in institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
CITY OR TOWN OR VILLAGE OR PLACE WHERE DECEASED Baltimore		ZIP CODE 21213	
NAME OF DECEASED Type of print Lillian I. Murphy		DATE OF DEATH June 11, 1967	
SEX Female RACE White		DATE OF BIRTH 9-19-96 AGE 70	
MARRIAGE STATUS WIDOWED		MONTHS 70 YEARS 11 DAYS 11 HOURS 11 MINUTES	
TYPE OF HOME Homemaker		COUNTRY USA	
FATHER'S NAME Horatio Snyder		MOTHER'S NAME Russell Journey	
CAUSE OF DEATH PART DEATH WAS CAUSED BY Heart failure		INFORMATION 3.7.16-0746	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE OF DEATH Heart failure		SIGNATURE OF DECEASED Lillian I. Murphy	
PRIMARY CAUSE OF DEATH Heart failure		SIGNATURE OF DECEASED Lillian I. Murphy	
I certify that the above is a true and correct statement of the facts as they appear on the records of the Baltimore County Health Department.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME AND TITLE CHARLES F. O'DONNELL, J.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE June 14, 1967		DATE SIGNED 6/14/67	
SIGNATURE OF DECEASED Lillian I. Murphy		SIGNATURE OF DECEASED Lillian I. Murphy	



TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death + necessary, please execute the certificate writing the word pending in parentheses Page 2 and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner. (If the closing with PM3, Page 5 may be retained for your file.)

TO FUNERAL DIRECTOR Page 3 should be used only burial/transport permit. Five copies of this certificate with the State Death Certificate should be submitted to the Health or Health Department within 72 hours after death.

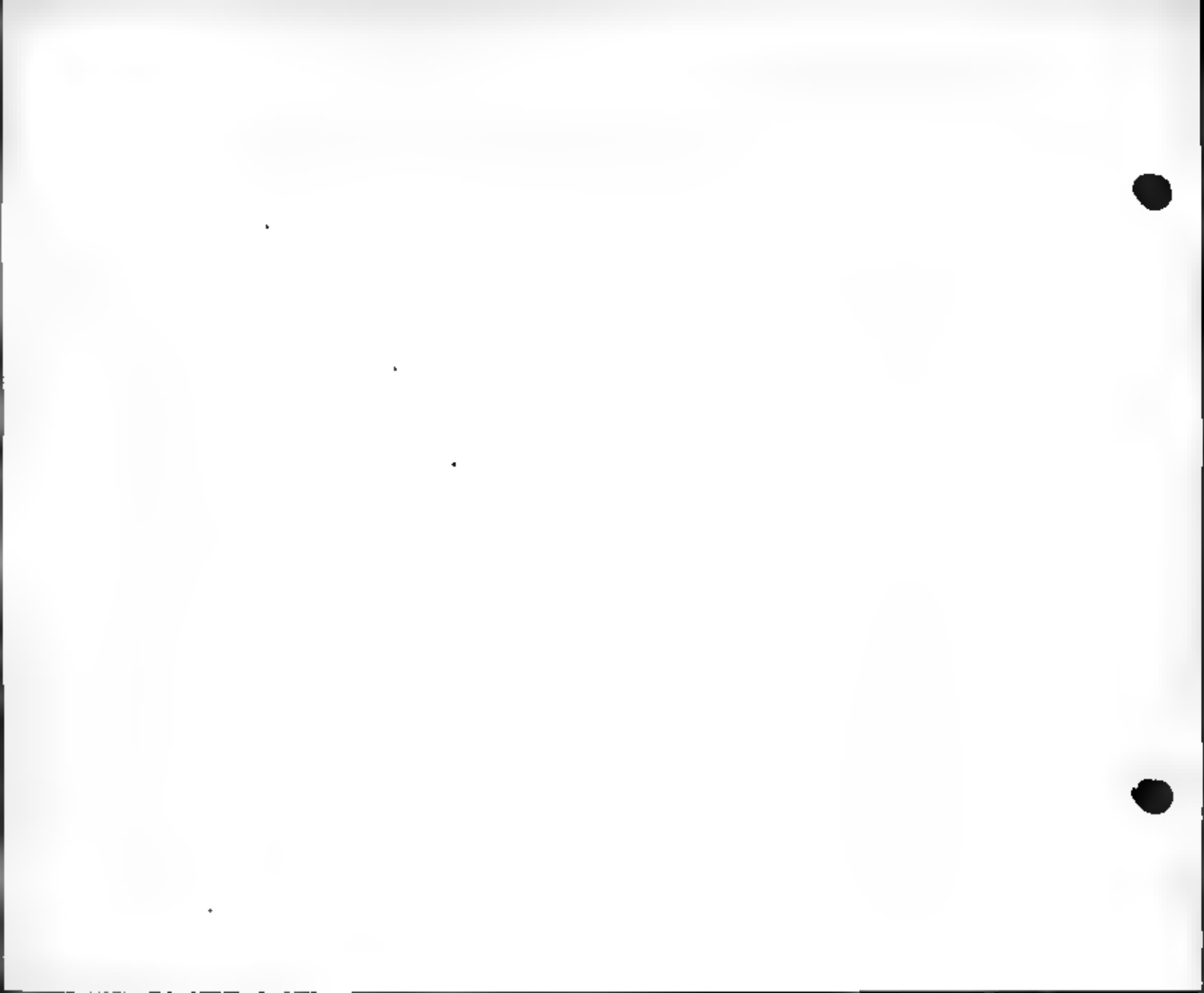
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

97852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07824

PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (If not same as place of death) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If not de corporate limit write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If not de corporate limit write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSURANCE (If not in Hospital give street address) 17 Ridgemoor Rd.		d. STREET ADDRESS 17 Ridgemoor Rd.	
e. NAME OF DECEASED Type of death LILLIE GRACE MYERS Female White d. COLOR OR RACE WIDOWER <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> e. OCCUPATION (If not in work done during most of working life, even if retired) Housewife f. KIND OF BUSINESS (If HOME INDUSTRY) Home		g. DATE OF BIRTH Feb. 11, 1884 h. AGE (If not in years) 83 i. BIRTHPLACE (State and territory) Penna. j. COUNTRY OF BIRTH USA	
k. WA. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		l. SOCIAL SECURITY NO. ?	
m. INFORMANT Earl A. Myers, Sr.		n. Address Same	
o. CAUSE OF DEATH (If not in Part I, give full description of disease or injury) A-5- + Hypertensive Cardio-vascular Disease		p. DATE OF DEATH 6/16/67	
q. PART II OTHER SIGNIFICANT CONDITIONS (Including chronic diseases, injuries, etc., which may be terminal or lead to terminal condition) None		r. DATE OF DEATH 6/16/67	
s. 1. CERTIFY that I took charge of the remains described above held on a temporary basis and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		t. 2. I certify that I took charge of the remains described above held on a temporary basis and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
u. ACTUAL SIGNATURE M. B. Davis		v. DATE SIGNED 6/16/67	
w. EXAMINER'S NAME M. B. Davis, M.D.		x. ADDRESS 6800 Mornington Rd., Dundalk, Md. 21222	
y. 3. NAME OF FUNERAL HOME Bricker Funeral Home		z. 4. CITY AND STATE Oberlin, Pa.	
aa. 5. NAME OF FUNERAL HOME Brudzinski Funeral Home		ab. 6. CITY AND STATE 1407 Eastern Ave.	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07853

07335

1. PLACE OF DEATH
a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN ID MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE

3. NAME OF DECEASED (Type or print) First Middle Last James H. Nelson 4. DATE OF DEATH Month Day Year 6-19-1967

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 12-25-1912 9. AGE (in years last birthday) Months Days Hours Min. 54 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR 10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT PLANT 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA 12. COUNTRY OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES H. NELSON 14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No 16. SOC. SEC. NO. 147 17. INFORMANT Mr. Theodore H. Nelson - 718 Princeton St. Carson, Cal. Address

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) ACHD
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH

19. WAS AN OPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS (a) MAJOR OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 White 20d. INJURY OCCURRED at work 20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) at work 20f. (City or town) (County) State

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Theodore H. Nelson M.D. 22. DATE SIGNED 6/19/67

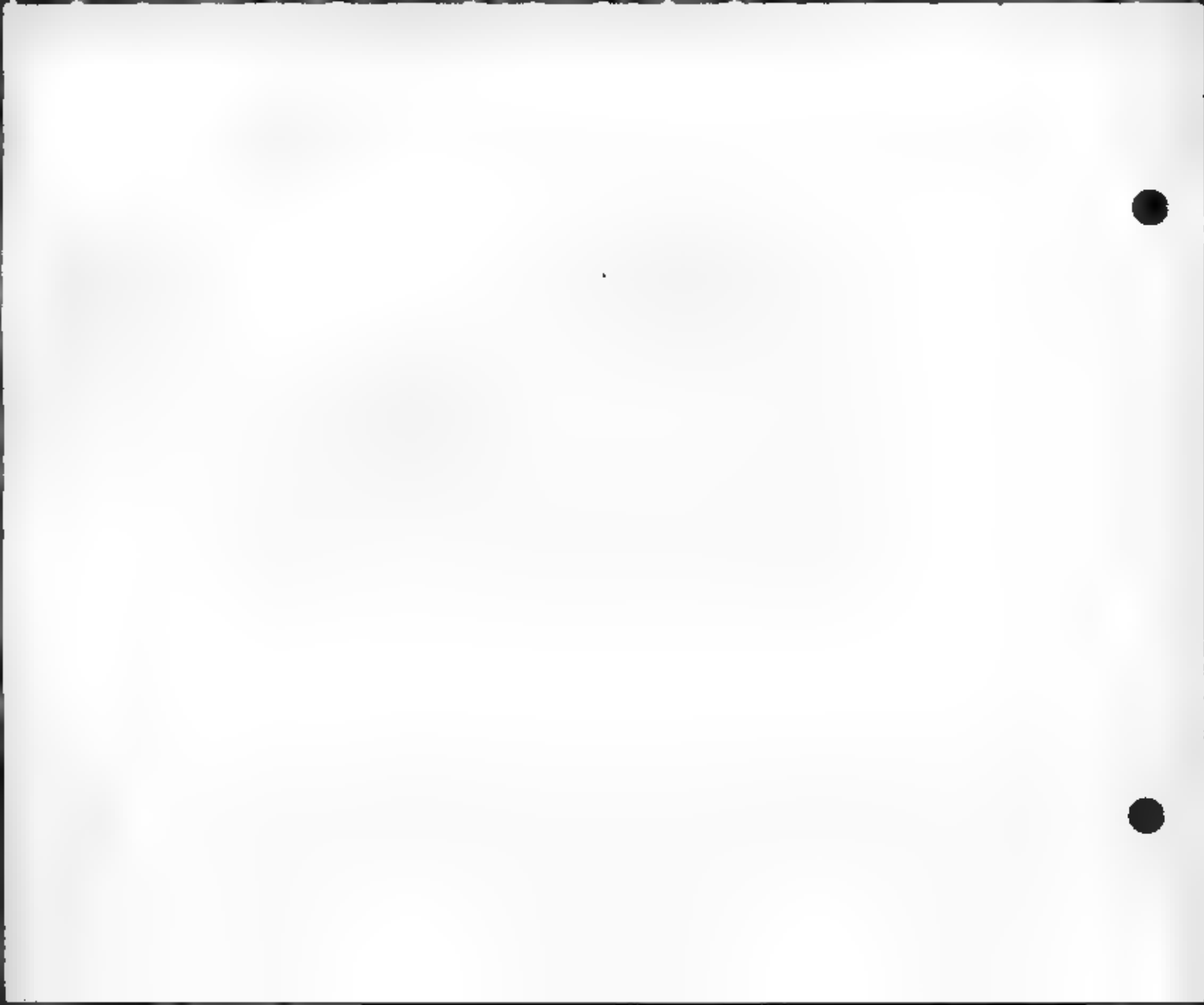
EXAMINER'S NAME (Type or print) C. Patterson, M.D. Address (Street, city, town, or county)

23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 6-24-67 23c. NAME OF CEMETERY OR CREMATORY HONOKE CEMETERY 23d. LOCATION (City, town or county) (State) HONOKE, ARKANSAS

FUNERAL DIRECTOR Stanley Miller - 2334 Jefferson St. ADDRESS 25a. REC'D BY REG. STRAR 6/19/67 25b. REG. STRAR'S SIGNATURE John Charles Judge DATE JUN 22 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

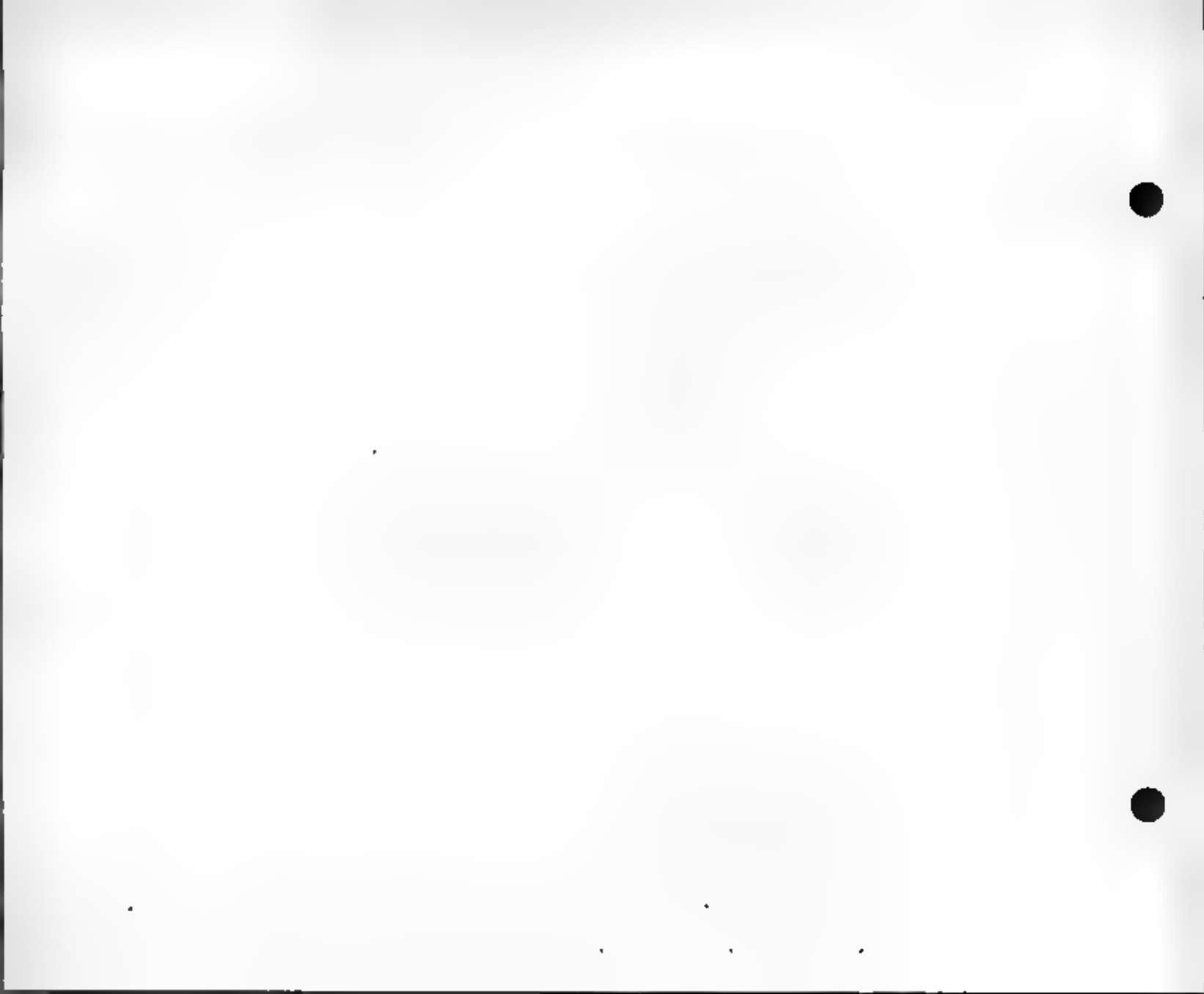
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



27036

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove obituary papers. Pages 1 and 2 should be filed with the State Dept. at the same time as burial, cremation or removal, and in any event, within 72 hours after death. Page 4 should be filed with the funeral home.



101X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death, if an autopsy is necessary, by the Director, or by a physician designated by the Director. Page 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07855 37831

1. PLACE OF DEATH
a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. LENGTH OF STAY IN b. life

2. USUAL RESIDENCE where deceased lived if institution Residence before death
a. STATE Md b. COUNTY Balto c. CITY OR TOWN Baltimore d. TRAIL ADDRESS 1100 Gilcrest

3. NAME OF DECEASED John Joseph O'Leary 4. DATE OF DEATH 6 11 1967

5. SEX M 6. COLOR OF RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH May 30, 1898 9. AGE 69 10. INJURY 24 HRS. PRIOR TO DEATH NO

11. CAUSE OF DEATH (Enter only one cause on line 11a and 11b and 11c)
11a. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE Atherosclerotic Cardiovascular Disease
11b. DUE TO Disease
11c. DUE TO Emphysema

12. CAUSE OF DEATH (Enter only one cause on line 12a and 12b and 12c)
12a. EXTERNAL CAUSE OF DEATH Emphysema
12b. DESCRIBE HOW AND BY WHAT MEANS (Enter within 24 hours of death in Part II of item 12)
12c. TIME OF INJURY 19 00 a.m. 12d. INJURY at work 12e. PLACE OF INJURY Home 12f. CITY OR TOWN Baltimore 12g. COUNTY Baltimore

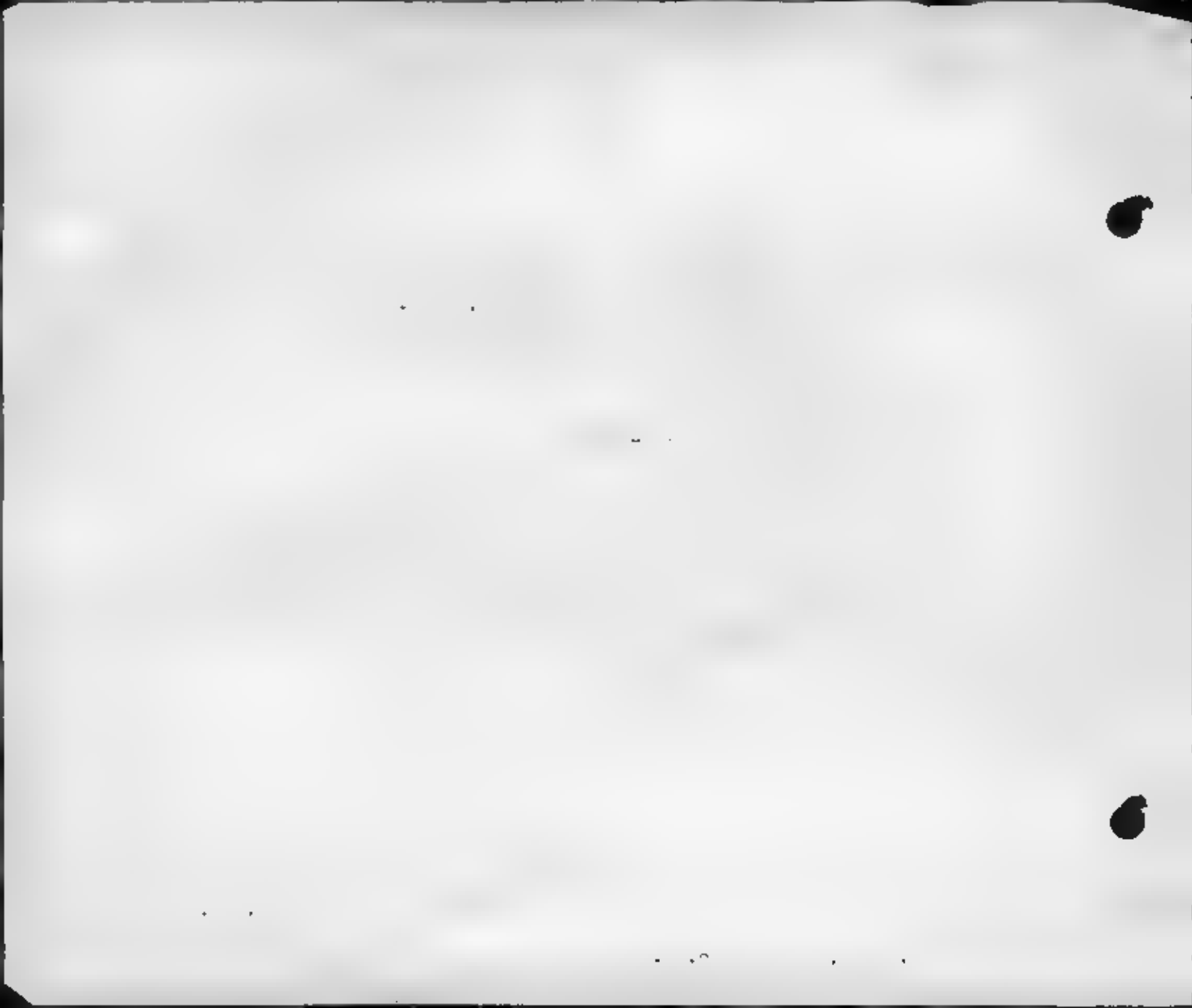
13. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

14. ACTUAL SIGNATURE FT. KASIK JR. MD 15. EXAMINER'S NAME FT. KASIK JR. MD 16. DATE SIGNED 6/11/67

17. BURIAL CREMATION Burial 18. DATE OF BURIAL 6/14/67 19. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery 20. LOCATION Baltimore, Md.

21. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 22. ADDRESS 21214 23. REC'D BY REGISTRAR REC'D BY REGISTRAR 24. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07856

CERTIFICATE OF DEATH

7833

PLACE OF DEATH a. COUNTY Baltimore		USUAL RESIDENCE (Where deceased lived) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write PLAT and give nearest town) Baltimore		c. LENGTH OF STAY IN IT 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balto. Medical Center		d. STREET ADDRESS 4128 Parkside Drive	
3. NAME OF DECEASED Type of print Clarence Leroy Palmer		4. DATE OF DEATH Month June Day 26 Year 1967	
5. SEX M	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY DuPont Co.	
3. FATHER'S NAME August Palmer		4. MOTHER'S MAIDEN NAME CLARA Schaub	
5. VA DEATH SERVICE IN ARMED FORCES? (Yes, no or unknown) no		6. SOCIAL SECURITY NO 212-01-6284	
7. INFORMANT Carrie Martin Palmer, wife, above		Address	
b. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a) Cardiomegaly failure b) Ca Lung c) Ca Lung		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACUTE OR CHRONIC DISEASE (this hospital) attended the deceased from 6-16 to 6-26 1967 and that death occurred on 6-26 1967 at 9:30 PM from colic and on the date stated above		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month Day Year June 26 1967		20d. INJURY BY TRUCK	
20e. PLACE OF INJURY Home (or factory street address) 4128 Parkside Drive		20f. City or town Baltimore County Baltimore State Md.	
21. I certify that (this hospital) attended the deceased from 6-16 to 6-26 1967 and that death occurred on 6-26 1967 at 9:30 PM from colic and on the date stated above		22. SIGNATURE RAM K CHHILLAR	
22a. PHYSICIAN'S NAME Type RAM K CHHILLAR		22b. DATE SIGNED 6/28/67	
23a. BURIAL OR CREMATION (Specify) Burial		23b. DATE THEREOF 6/30/67	
23c. NAME OF FUNERAL HOME OR REMATORY Loudon Park Cemetery		23d. ADDRESS Baltimore, Md.	
23e. NAME OF FUNERAL HOME OR REMATORY Schimunek Funeral Home, Inc.		23f. ADDRESS 3331 Brehms Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health in Baltimore, Maryland.



10 HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After the certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial permit. Then place in appropriate carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET BALTIMORE MARYLAND 21201

07857

CERTIFICATE OF DEATH

7-23

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Baltimore County c NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address Greater Baltimore Medical Center		USUAL RESIDENCE (Where deceased lived) Institution Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Baltimore d STREET ADDRESS 8208 Laurel Drive	
3 NAME OF DECEASED (Type in print) First DELTA Middle ALSTON Last PALMER		4 DATE OF DEATH Month June Day 16 Year 1967	
5 SEX Female 6 COLOR OR RACE Caucasian 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Nov. 17, 1922 9 AGE at last birthday 44 yrs	
10a FULL OCCUPATION (If working at work done during year of working, list even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY None	
11 FATHER'S NAME William Ernest Cox		12 MOTHER'S MAIDEN NAME Lillian Harris	
13a OFF AND EVER IN ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, OR OTHER SERVICE (If yes, give date of entry and date of discharge) No		13b SOCIAL SECURITY NO. (unknown)	
14 CAUSE OF DEATH (Enter only one cause per line. Put in "b" and "c" for immediate cause, "d" for underlying cause, and "e" for contributing cause.) PART I DEATH WAS CAUSED BY a IMMEDIATE CAUSE (a) Metastatic Carcinoma of Appendix b DUE TO c UNDERLYING CAUSE (b) Metastatic Carcinoma of Appendix d CONTRIBUTING CAUSE (c) Metastatic Carcinoma of Appendix		15 INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH OR NOT RELATED TO THE TERMINAL DISEASE (INDICATE GIVEN IN PART I-c)			
20a ALL DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If other than medical examiner) Yes		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 8.)	
20c TIME OF INJURY Month Day Year June 19 1967		20d PLACE OF INJURY Home farm factory street office bldg. etc. Home	
20e INJURY BY White <input type="checkbox"/> Not White <input type="checkbox"/> Other <input type="checkbox"/>		20f CITY OR TOWN State Baltimore Md.	
21 certify that this hospital attended the deceased from 5/15/67 to 6/16/67 and that death occurred at 8:15 AM on the date stated above			
22 SIGNATURE John E. Adams		23 PHYSICIAN'S NAME John E. Adams, M.D.	
24 BUREAU OF HEALTH C.F. EVANS & SON 8802 Harford road		25 FILED BY REG. TRAC JUN 19 1967	

VR 415 41
25M 1 67



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07858

CERTIFICATE OF DEATH

07840

1. PLACE OF DEATH a. COUNTY <u>PA. T.</u> b. CITY OR TOWN <u>PA. T.</u> c. NAME OF HOSPITAL OR INSITU. OR, if not in hospital, give street address <u>PA. T.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BA. & C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PA. T.</u> d. STREET ADDRESS <u>PA. T.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Type or print <u>PA. T.</u> f. SEX <u>F</u> g. COLOR OR RACE <u>W</u> h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> i. DATE OF BIRTH <u>SEPT 29, 1887</u> j. AGE (in years, last birthday) <u>77</u> k. IF UNDER 1 YEAR: Months <u>1</u> Days <u>9</u> Hours <u>7</u> l. IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1967</u> m. BIRTHPLACE (County & state or foreign country) <u>GA.</u> n. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PA. T.</u>		14. MOTHER'S MAIDEN NAME <u>PA. T.</u>	
15. DECEASED'S SERVICE (If in armed forces, give war or dates of service) <u>PA. T.</u>		16. SOCIAL SECURITY NO. <u>26 28 667</u>	
17. INFORMANT <u>PA. T.</u>		Address <u>PA. T.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, a, b, and c) PART I: DEATH WAS CAUSED BY a. IMMEDIATE CAUSE (a) <u>Terminal illness</u> b. DUE TO <u>Ulcerative Colitis</u> c. DUE TO <u>10 yrs</u> d. Conditions, any which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. <u>PA. T.</u>			
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) b. TIME OF INJURY: Month <u>6</u> Day <u>10</u> Year <u>1967</u> Hour <u>9</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item B.) 20a. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20b. PLACE OF INJURY: Home farm <input type="checkbox"/> Factory street, office bldg. etc. <input checked="" type="checkbox"/> 20c. (City or town) (County) (State) <u>PA. T.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/14</u> 19 <u>67</u> to <u>6/10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> 19 <u>67</u> and that death occurred at <u>9 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>G M Balmgardner</u> 22b. PHYSICIAN'S NAME Type <u>G M Balmgardner</u>		22c. DATE SIGNED <u>6/13/67</u> 22d. ADDRESS <u>300 MACE</u>	
23a. BURIAL REMOVAL REMOVAL (Specify) <u>B.M.</u>		23b. DATE THEREOF <u>6/13/67</u>	
23c. NAME OF CEMETERY OR REMOVAL <u>A. ADAM RIDGE</u>		23d. LOCATION (City or town) (County) (State) <u>PA. T.</u>	
24. FUNERAL DIRECTOR <u>JG CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or entombment in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, fill in by the funeral director page 3 that it be detached to use as the burial permit. Then please remove the top page 1 and 2 should be filed with the State Dept. of Health prior to be cremated or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Catonsville		2 USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a STATE Maryland b COUNTY Cecil c CITY OR TOWN If outside corporate limits, write RURAL and give nearest town North East, Maryland	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		4 STREET ADDRESS none	
5 NAME OF DECEASED First Middle Last Margaret Parsons		6 DATE OF DEATH Month Day Year June 16 1967	
7 SEX female	8 COLOR OR RACE white	9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH 8/4/1878
11 OCCUPATION (If kind of work done during most of working life, even if retired) housewife		12 KIND OF BUSINESS OR INDUSTRY own	
13 FATHER'S NAME unknown		14 MOTHER'S MAIDEN NAME unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown, if yes give war or dates of service) No		16 SOCIAL SECURITY NO 219-54-3265T	
17 CAUSE OF DEATH (Enter only one cause per part; for Part I, I, II, and III, enter the immediate cause; for Part II, enter the underlying cause; for Part III, enter the contributing cause) PART I: CHLORAS PNEUMONIA PART II: ARTERIO-SCLEROTIC HEART DISEASE PART III: Pneumonia		18 BIRTHPLACE (Country & State or foreign country) Maryland	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) none		20 MEDICAL CERTIFICATE 20a IDENTIFYING INJURY UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury & Part I or Part II of item 18) 20c TIME OF INJURY Month Day Year 20d INJURY OF OR BY 20e PLACE OF INJURY Name of place, factory, street, office, etc. 20f CITY OR TOWN 20g STATE	
21 I certify that (this hospital) attended the deceased from Aug. 24 to 6/16/67 and her death occurred on 6/16/67 from causes and on the date stated above.		22 SIGNATURE Richard L. Gooden, M.D.	
23 PHYSICIAN NAME Type DR. RICHARD L. GOODEN		24 ADDRESS SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228	
25 BURIAL OR CREMATION 25a DATE 6/20/67		25b NAME OF CEMETERY OR CREMATOR West Nottingham Cem. Colora, Cecil, Md.	
26 FUNERAL DIRECTOR Richard L. Gooden		27 REGISTRATION 20 1967	



1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN "If outside corporate limits, write R. R. and give nearest town" Port Howard		2 USUAL RESIDENCE "Where deceased lived if inst'd in residence before death" a STATE Maryland b COUNTY Anne Arundel	
c LENGTH OF STAY IN 1b 10 Days		d CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town" Shady Side	
3 NAME OF HOSPITAL OR INSTITUTION "If not in hospital give street address" Veterans Administration Hospital		4 STREET ADDRESS Box 75	
5 NAME OF DECEASED (Type or print) JOHN (NMI) PETRIE		6 DATE OF DEATH Month JUNE Day 3 Year 67	
7 SEX Male	8 COLOR OR RACE White	9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH 7/3/98
11 SOCIAL OR "UPA" ID "Give kind of work done during past 10 working life, even if retired" Inspector		12 KIND OF BUSINESS OR NO. TRV Treasury Dept	13 BIRTHPLACE "County & state of birth" Scotland
14 FATHER NAME William Petrie		15 MOTHER AND DEN NAME Mary McGovern	
16 DECEASED EVER IN ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) Yes WW I		17 SOCIAL SECURITY NO. 213 36 5690	
18 INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md.		19 ADDRESS	
20 CAUSE OF DEATH "Enter only one cause per line for 1a, 1b and 1c" PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE "a" ACUTE PULMONARY EDEMA DUE TO CONDITIONS (any which gave rise to immediate cause, stating the underlying cause) 1b BLEEDING ESOPHAGEAL VARICES DUE TO 1c ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH Few hours Few Weeks Years	
21 OTHER SIGNIFICANT CONDITIONS CONTRIB. INC. D. 1a, 1b BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN 1a, 1b, 1c CIRRHOSIS OF LIVER		22 "Was it directly PERFORMED?" Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
23a ANATOMICAL INQUIRY OR "RIB" INFO <input type="checkbox"/> AUS. CH. DEATH (IF FATHER, NOTIFY MEDICAL EXAMINER)		23b DESCRIBE HOW INJURY OCCURRED "Enter nature of injury in Part 23a Part 23b of item B."	
24 TIME OF INJURY Month Day Year Hour min. p.m. 19		25 INJURY OF INJURY While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	26 PLACE OF INJURY "Home, farm, factory, street, office bldg, etc."
27 I certify that the this hospital attended the deceased from May 24 19 67 to June 3 19 67 that <input checked="" type="checkbox"/> we were law the deceased place on June 3 19 67 and that death occurred at 4:45 PM on June 3 19 67 and on the date stated above		28 SIGNATURE 29 PHYSICIAN'S NAME YPO WON JU HAHN, M.D.	
30 ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> 31 DATE SIGNED 6/4/67		32 ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
33 BURIAL REMOVAL (REMOVAL, specify) Burial	34 DATE OF BURIAL 6/7/67	35 NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	36 CITY OR TOWN Arlington, Virginia
37 FUNERAL DIRECTOR Francis Gash Sons Fun. Home		38 ADDRESS 4739 Baltimore Ave	39 CITY OR TOWN Hyattsville, Md.
40 BY REGISTRAR Francis Gash		41 SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07861

07843

PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN Towson c. NAME OF HOSPITAL OR INSTITUTION Greater Balto Med Center		USUAL RESIDENCE Where deceased lived for 1 year before admission a. STATE Baltimore b. COUNTY c. CITY OR TOWN Baltimore d. STREET ADDRESS 2902 Bowers Ave		RESIDENCE ON A. A. M. YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECLARED First Nicholas Middle Piacentino Last Piacentino		4. DATE OF DEATH Month 6 Day 23 Year 1967			
5. SEX Male 6. COLOR OR RACE Cauc 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-1894 9. AGE in years 73 months 7 days 23		10. UNDER 1 YEAR 73 Wks. 7 Days 23 Hours 23 Min	
11. US. AL. T. PATIENT Give kind of work done during morn. of working life even if retired Tailor		12. KIND OF BUSINESS OR INDUSTRY Italy		13. BIRTHPLACE County & State or foreign country USA	
14. FATHER'S NAME Giovanni Piacentino		15. MOTHER'S MAIDEN NAME Christina Urbano			
16. WA. DR. A. A. VERIN Yes 17. ARMY AIR FORCE WW I 18. SOCIAL SECURITY NO. 216-05-0471		19. INFORMANT Christina Piacentino Address 2902 Bowers Ave			
20. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure (b) Carcinoma of the (R) Lung (c) 6 months		21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH Severe metastases from the lung; Chronic emphysema		22. INTR. B. BETWEEN ONLY AND DEATH 24 hrs	
23. TIME OF INJURY Month, Day, Year Hour, min. 19		24. INJURY IN INJURY White <input type="checkbox"/> Not White <input type="checkbox"/> 25. PLACE OF INJURY Home		26. CITY OR TOWN Baltimore 27. COUNTY Baltimore 28. STATE Md	
29. I certify that (this hospital) attended the deceased from 6/23 1967 to 6/23 1967 and that death was caused by 11:45 P.M. from causes and on the date stated above		30. SIGNATURE Derek A Bruce M.D. ATTENDING PHYS. <input type="checkbox"/> M.D. DIR. FOR <input type="checkbox"/> A. PHYS. <input type="checkbox"/>		31. DATE SIGNED 6/23/67	
32. PHYSICIAN'S NAME Type DEREK A. BRUCE		33. ADDRESS G. B. M. C.			
34. NAME OF CEMETERY OR REMAINDER Lorraine Cemetery		35. DATE OF BURIAL OR REMAINDER 6-27-1967		36. ADDRESS Baltimore, Maryland	
37. FUNERAL DIRECTOR Ellsworth Armacost		38. ADDRESS 4600 Liberty Hgts. Avenue		39. DATE 26 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

37862

CERTIFICATE OF DEATH

37845

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained by the funeral director. Page 1 and 2 should be filed with the State Department of Health. Page 3 should be filed with the State Department of Health.

PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN FORT HOWARD c. STATE MARYLAND		USUAL RESIDENCE Where deceased lived. If institution, residence before admission a. STATE MARYLAND b. CITY OR TOWN ANNE ARUNDEL c. COUNTY ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 1931 DREW STREET	
f. NAME OF DECEASED ALEXANDER NMI PINKNEY		g. DATE OF DEATH JUNE 18, 1967	
h. SEX MALE		i. RACE NEGRO	
j. MARRIAGE STATUS NEVER MARRIED		k. DATE OF BIRTH 10/16/90	
l. OCCUPATION BAKER		m. PLACE OF BIRTH U.S. NAVAL ACADEMY, ANNAPOLIS, MARYLAND	
n. FATHER'S NAME WILLIAM PINKNEY		o. MOTHER'S MAIDEN NAME JULIA WALLACE	
p. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		q. SOCIAL SECURITY NO 220 14 63 30	
r. CAUSE OF DEATH CARCINOMA OF THE COLON WITH GENERALIZED METASTASIS		s. INTERVAL BETWEEN DEATH AND EXAMINATION UNKNOWN	
t. TIME OF INJURY June 2, 1967		u. PLACE OF INJURY VA HOSPITAL, FORT HOWARD, MARYLAND	
v. I certify that the deceased died at the hospital attended by the attending physician and that death was caused by the disease or condition stated above.		w. SIGNATURE OF PHYSICIAN Angelita A. Topacio, M.D.	
x. SIGNATURE OF FUNERAL DIRECTOR William Reese		y. ADDRESS OF FUNERAL HOME 108 W. Washington St., Annapolis, Md.	

...

...

...

...

...

...

...

...

...

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07863

CERTIFICATE OF DEATH

07846

1 PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN <u>Baltimore</u> c. STREET ADDRESS <u>Greater Baltimore Med Cen</u>		2 USUAL RESIDENCE 'Where deceased lived, if institution' Res. before admission a. STATE <u>Md.</u> b. COUNTY <u>Baltimore, Md.</u> c. CITY OR TOWN <u>Baltimore, Md.</u> d. STREET ADDRESS <u>2503 Topaz Rd</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First Middle Last <u>Veronica F. Eleanor Pittroff</u>		4 DATE OF DEATH Month Day Year <u>6 5 1967</u>		5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u>	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>6/24/06</u>		9 AGE <u>60</u> years <u>60</u> months <u>60</u> days	
10a. MAIN OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & state or foreign country) <u>Baltimore, Md.</u>	
12 FATHER'S NAME <u>John T. Maylan (de)</u>		13 MOTHER'S MAIDEN NAME <u>Mary C. Wright</u>		14 INFORMANT <u>Frederick W. Pittroff 2503 Topaz Rd</u>	
15a. A. OFFICER DECEASED IN ARMED FORCES Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or date of service)		15b. SOCIAL SECURITY NO		16 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO a. <u>Acute myocardial infarction</u> b. <u>3d day</u> c. <u></u>	
17 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		18a. IDENTIFY UNDERLYING CAUSE OF DEATH OR "RUBRIC" IN A.S.D. OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of Form B)	
19a. TIME OF INJURY Month Day Year Hour AM PM <u>9</u>		19b. PLACE OF INJURY (Home town, street, address, floor, building etc.)		19c. CITY or town county State	
20a. I certify that if this hospital attended the deceased from <u>June 3rd 1967</u> to <u>June 5th 1967</u> that we saw the deceased alive on <u>June 5th 1967</u> and his death occurred at <u>5:15 PM</u> from causes and on the date stated above		20b. SIGNATURE <u>Dr. A. R. Nick</u>		20c. PHYSICIAN'S NAME (Type) <u>Dr. A. R. Nick</u>	
21a. SURVIVOR REMOVAL (Specify)		21b. DATE THEREOF <u>6/8/67</u>		21c. NAME OF CEMETERY OR INTERMENT <u>Baltimore Cemetery</u>	
22a. REGISTERED BY REGISTRAR		22b. REGISTERED BY REGISTRAR		22c. REGISTERED BY REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and placed in the burial record as the burial record. Page 1 and 2 should be filed with the State Department of Health prior to burial. A removal of the certificate prior to burial is prohibited.

USA 5-4
250-1-2-4

88

Philip E. Crach 121 Chesapeake Ave

DATE JUN 7 1967



1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Convalescent Home		d. STREET ADDRESS 4305 Plumer Avenue 36	
3. NAME OF DECEASED First Louise Middle F. Last Plumer		4. DATE OF DEATH Month 6 Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1883
9. AGE In years 83 lost birthday <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10. IF UNDER 1 YEAR: Months 3 Days 18 Hrs. 07	
11a. OCCUPATION (Give kind of work done during life, even if retired) Produce stand		11b. KIND OF BUSINESS OR INDUSTRY Delair Market	
12. BIRTHPLACE (Country & State or foreign country) Baltimore Co. Md.		13. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Frederick Plumer		15. MOTHER'S MAIDEN NAME Margaret Snyder	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown. If yes give war or dates of service) No		17. SOCIAL SECURITY NO 217-36-1371	
18. INFORMANT Miss Clara E. Plumer		Address 4305 Plumer Ave. 36	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions at any which gave rise to immediate cause & stating the underlying cause has (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3 weeks 1 yr 2 mo 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION CAUSE IN PART I (a)		19. WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AEC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF OTHER, NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)	
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 12/18/66		20f. (City or town) (County) (State) 6/18/67	
21. I certify that (1) (this hospital attended the deceased from 6/18/67 to 6/18/67 and that death occurred at 3 AM from causes and on the date stated above			
22a. SIGNATURE W E Mc Grath		22b. DATE SIGNED 6/18/67	
22c. PHYSICIAN'S NAME Type I W E Mc Grath		22d. ADDRESS 1303 Fridman Rd Catonsville	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-1967	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR Funeral Home		25a. REC'D BY REGISTRAR JUN 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.



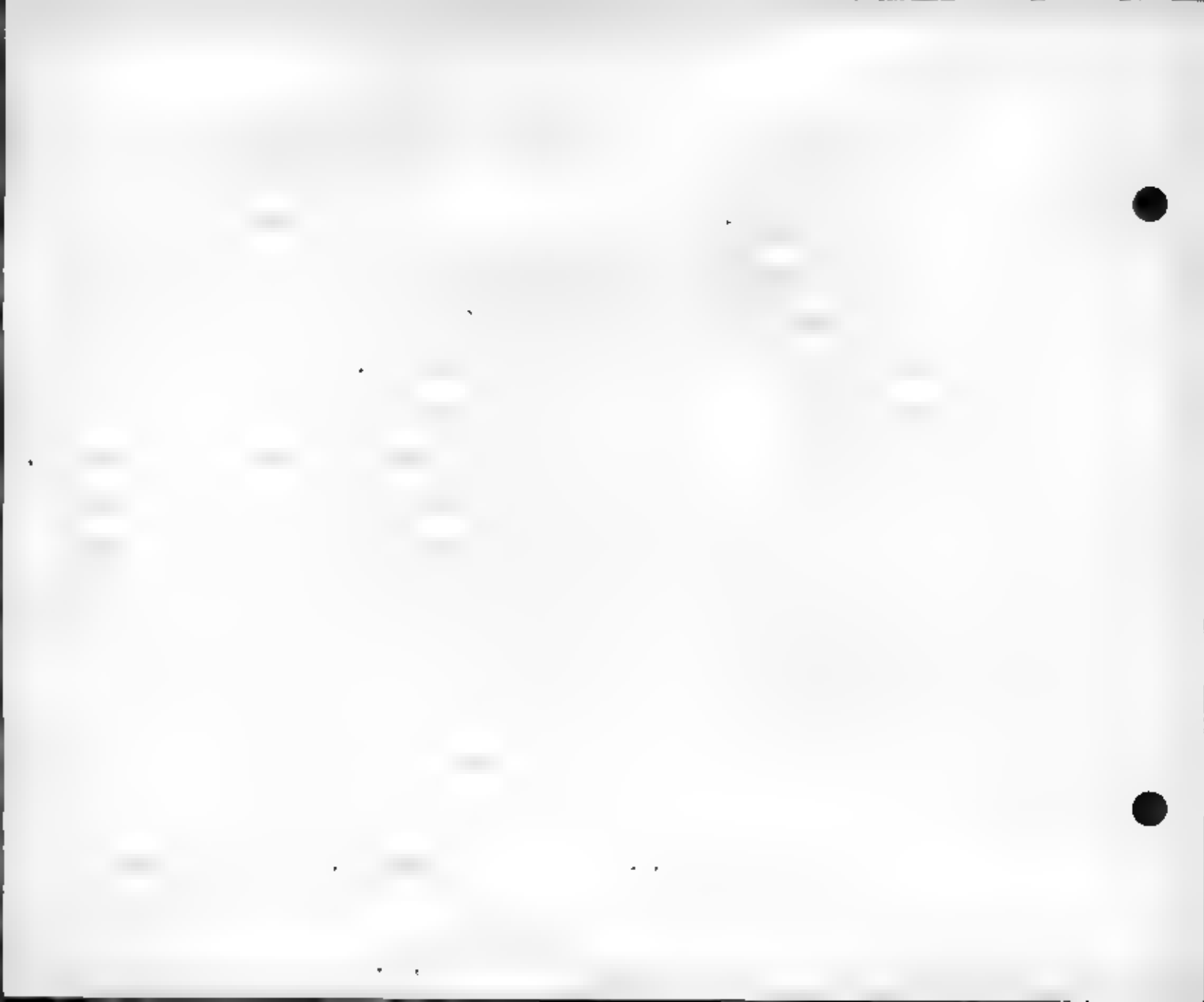
1
 67865
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07543

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Fort Howard		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE Maryland b COUNTY Baltimore	
c CITY OR TOWN Fort Howard d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e CITY OR TOWN Baltimore f STREET ADDRESS 7 University Avenue	
3 NAME OF DECEASED (Type or print) First EDWARD Middle HENRY Last POBLETT		4 DATE OF DEATH June 4 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/22/92
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b KIND OF BUSINESS OR INDUSTRY State Department	
10a BIRTHPLACE (County & State, or if foreign, country) Baltimore, Md.		10b COUNTRY U.S.A.	
11 FATHER'S NAME Edward Pobletta		12 MOTHER'S MAIDEN NAME Ellie (unknown)	
13 MARITAL STATUS (If ever married, give date of marriage) Yes		14 SOCIAL SECURITY NO. 220 36 86 10	
15 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) a IMMEDIATE CAUSE MYOCARDIAL INFARCTION b DUE TO ARTERIOSCLEROTIC HEART DISEASE c DUE TO		16 INFORMANT Clinical Recs, VA Hospital, Fort Howard, Md.	
17 PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH SUB NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)		18 YEARS Days	
19a ALLEGEDLY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If father, notify medical examiner)		19b DESCRIBE HOW INJURY OCCURRED (Fatal nature of injury in Part I or Part II a claim is)	
20a TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b PLACE OF INJURY Home, farm, factory, street, office, bldg, etc. VA Hospital, Fort Howard, Maryland	
21 I certify that (this hospital) attended the deceased from May 29 1967 to June 4 1967 that (we) last saw the deceased alive on June 4 1967 and that death occurred at 6:30 P.M. from causes and on the date stated above.		22a SIGNATURE WON JU HAHN, M.D.	
23a BURIAL INFORMATION (Removal, specify) Burial		23b DATE OF BURIAL 6-8-1967	
24 FUNERAL DIRECTOR HIGGINBOTHAM FUNERAL HOME		25 NAME OF EMBERY OR REMAINTY Good Shepherd	
26 ADDRESS 106 Columbia Rd, Ellicott City, Md.		27 DATE SIGNED JUN 6 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove all burials. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

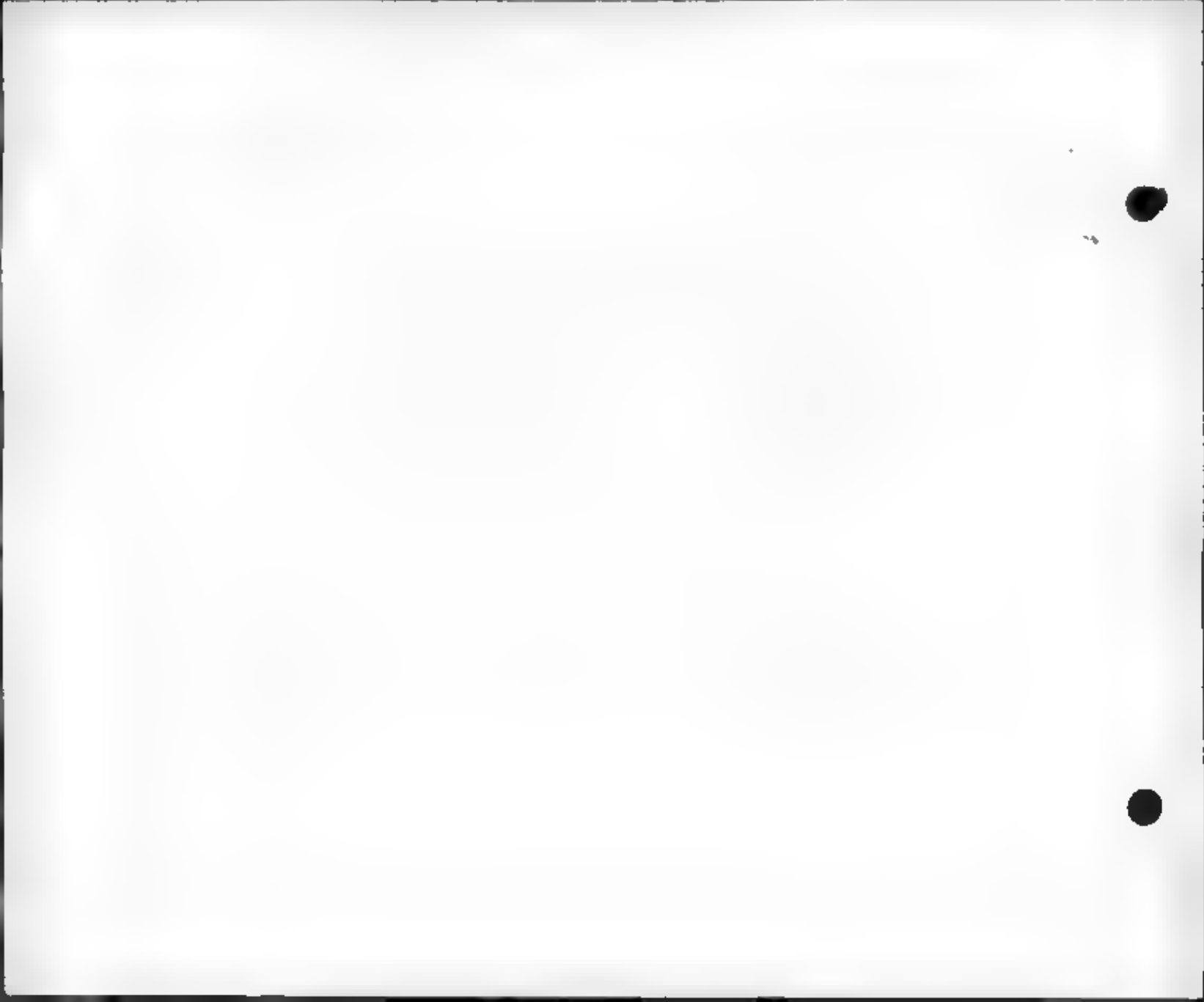
07866

07043

PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		e. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) d. STATE MD e. COUNTY Washington Co f. CITY OR TOWN (If outside corporate limit, write RURAL and give nearest town) Hagerstown g. STREET ADDRESS 341 W Washington St h. IF RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
i. NAME OF DECEASED (Type & print) First Middle Last Lip Northington Perish j. SEX Male k. COLOR OR RACE White l. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> m. AGE in years for birthday 49 n. UNDER 1 YEAR Months Days Hours Min 6 16 19 67 o. IF UNDER 24 HRS 11 5 4 p. DATE OF DEATH Month Day Year 6 16 19 67 q. BIRTHPLACE (County & State or foreign country) Maryland r. IN OF WHAT COUNTRY? U.S.A.		12. FATHER'S NAME Lewis Powell 13. MOTHER'S MAIDEN NAME Stella Lewis	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 15. SOCIAL SECURITY NO 213 18 075		16. INFORMANT Records, Mt. Wilson State Hospital Address	
17. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) a. PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE (or) 001 1 b. DUE TO c. DUE TO d. CONDITIONS, any which gave rise to immediate cause (a), stating the underlying cause last		18. Far advanced Pulmonary Tuberculosis 19. INTERVAL BETWEEN ONSET AND DEATH 6 months	
20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if item B) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if item B) 20c. TIME OF INJURY Month Day Year Hour : m p.m. 20d. NATURE OF INJURY When at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, athletic field, etc.) 20f. CITY or town 20g. STATE			
21. I certify that if this hospital attended the deceased from 6-1 9 67 to 6-16 9 67 hours we follow the deceased since on 6-16 19 67 and that death occurred at 6:16 AM from causes and on the date stated above 22a. SIGNATURE Wm. Newcomer 22b. DATE 6-16-1967 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. 22d. ADDRESS Mt. Wilson, Maryland			
23a. RURAL CREMATION (If cremated, specify) Funeral 23b. DATE HEREOF June 18, 1967 23c. NAME OF CEMETERY OR BURIALITY Thosomiddle 23d. LOCATION (City or town, county, state) Myersville Ind. Md. 23e. REC'D BY REGISTRAR Carl F. Bille 23f. REGISTRAR'S SIGNATURE Myersville, Md.		24. JUNE 20 1967	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove the bar paper labels and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and no any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07867

CERTIFICATE OF DEATH

07 50

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN FORT HOWARD c LENGTH OF STAY IN b 23 DAYS		2 USUAL RESIDENCE Where deceased spent if institution Residence before admission a STATE MARYLAND b CITY OR TOWN BALTIMORE	
d NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address VETERANS ADMINISTRATION HOSPITAL		e STREET ADDRESS 3526 PARKLAWN AVENUE	
3 NAME OF DECEASED First HENRY Middle ANTON Last PRIMUS		4 DATE OF DEATH Month JUNE Day 18 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/9/12
9 AGE 54 years		10 UNDER 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> 10-15 years <input type="checkbox"/> 15-20 years <input type="checkbox"/> 20-25 years <input type="checkbox"/> 25-30 years <input type="checkbox"/> 30-35 years <input type="checkbox"/> 35-40 years <input type="checkbox"/> 40-45 years <input type="checkbox"/> 45-50 years <input type="checkbox"/> 50-55 years <input type="checkbox"/> 55-60 years <input type="checkbox"/> 60-65 years <input type="checkbox"/> 65-70 years <input type="checkbox"/> 70-75 years <input type="checkbox"/> 75-80 years <input type="checkbox"/> 80-85 years <input type="checkbox"/> 85-90 years <input type="checkbox"/> 90-95 years <input type="checkbox"/> 95-100 years <input type="checkbox"/>	
11 PLACE OF BIRTH STOCK CHASER		12 KIND OF BUSINESS OR OCCUPATION Gen. Motors AUTOMOBILE	
13 FATHER'S NAME ANTON PRIMUS		14 MOTHER'S MAIDEN NAME OTELLIE HILSHER	
15 Was he ever in Armed Forces? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes give date of discharge WHIT		16 SOCIAL SECURITY NO 215 09 77 18	
17 Informant Alberta Primus, (nee Miller) Above.		18 CLINICAL RECORDS, VAH, FORT HOWARD, MD.	
19 CAUSE OF DEATH (a) Immediate cause (b) Underlying cause (c) Contributing cause (d) Cause of death (e) Other		20 INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
21 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH OR NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		22 MEDICAL SIGNATURE	
23a AD. DEPT. WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER		23b DESCRIBE HOW INJURY OR DURED Enter notation of injury in Part I or Part II of item 8.	
24a TIME OF INJURY Month, Day, Year		24b INJURY BY (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and placed in the "page 3" folder. The funeral director should file the certificate with the State Dept. of Health prior to burial. The law requires that the death certificate be executed within 24 hours after death.

f

4 4 4

.

1 1

2 2

.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07868

07551

1. PLACE OF DEATH a. COUNTY BALTIMORE b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived a. STATE MARYLAND b. COUNTY _____)	
b. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town" BALTIMORE		c. LENGTH OF STAY IN AB. 52 D. YS	
d. NAME OF HOSPITAL OR AMBULANCE "If not in hospital, give street address." JOSEPH PUCHAJDA		e. STREET ADDRESS 3710 N. MOUNT ST. E.	
3. NAME OF DECEASED a. First Name JOSEPH b. Middle P c. Last PUCHAJDA		4. DATE OF DEATH Month JUNE Day 23 Year 1967	
5. SEX MALE a. COLOR OR RACE WHITE		6. DATE OF BIRTH Month 10 Day 17 Year 1916	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE in yrs. at birthday Month 7 Day 0 Year 50	
10. SOCIAL OCCUPATION "Give kind of work done during most of working life (even if retired)" PILOT		11. BIRTHPLACE (County & State, or Foreign country) PUCELE, PENNA.	
12. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		13. CITIZEN OF WHAT COUNTRY U.S.A.	
14. FATHER'S NAME LOUIS PUCHAJDA		15. MOTHER'S MAIDEN NAME PUCELE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, give war or dates of service		17. SOCIAL SECURITY NO. 218 10 32 69	
18. INFORMANT JOSEPH PUCHAJDA, VAN, ST. HYLAND, MD.		Address _____	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS A RESULT OF IMMEDIATE CAUSE (a) DIABETIC GANGRENE, LEFT LEG DUE TO (b) DIABETIC NEUROPATHY AND RETINOPATHY DUE TO (c) DIABETES MELLITIS		INTERVAL BETWEEN DEATH AND YEARS 20 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH OR RELATED TO THE PERMANENT CONDITION GIVEN IN PART I ARTERIOSCLEROSIS OBLITERANS, LEGS		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18)	
21. TIME OF DEATH Hour 3:10 PM Minute 00 Day 23 Month JUNE Year 1967		22. PLACE OF DEATH a. City or town BALTIMORE b. County BALTIMORE c. State MARYLAND	
23. I certify that this has been attended by the attending physician from MAY 2, 1967 to JUNE 23, 1967 that he saw the deceased give an ORAL EXAMINATION and that death occurred at 3:10 PM on the date so stated above.		24. SIGNATURE OF ATTENDING PHYSICIAN WILLIAM H. HILSON, M.D.	
25. PHYSICIAN'S NAME Type WILLIAM H. HILSON, M.D.		26. ADDRESS 1415 S. IVY ST., BALTIMORE, MD.	
27. RURAL EXAMINER (Name) JOSEPH PUCHAJDA		28. DATE OF EXAMINATION 6/23/67	
29. NAME OF FUNERAL HOME OR REMAINERS P. LITTON & SONS, INC., BALTIMORE, MD.		30. NAME OF FUNERAL HOME OR REMAINERS (County & State) P. LITTON & SONS, INC., BALTIMORE, MD.	
31. FUNERAL DIRECTOR JOSEPH PUCHAJDA		32. DATE OF BURIAL OR CREMATION JUNE 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

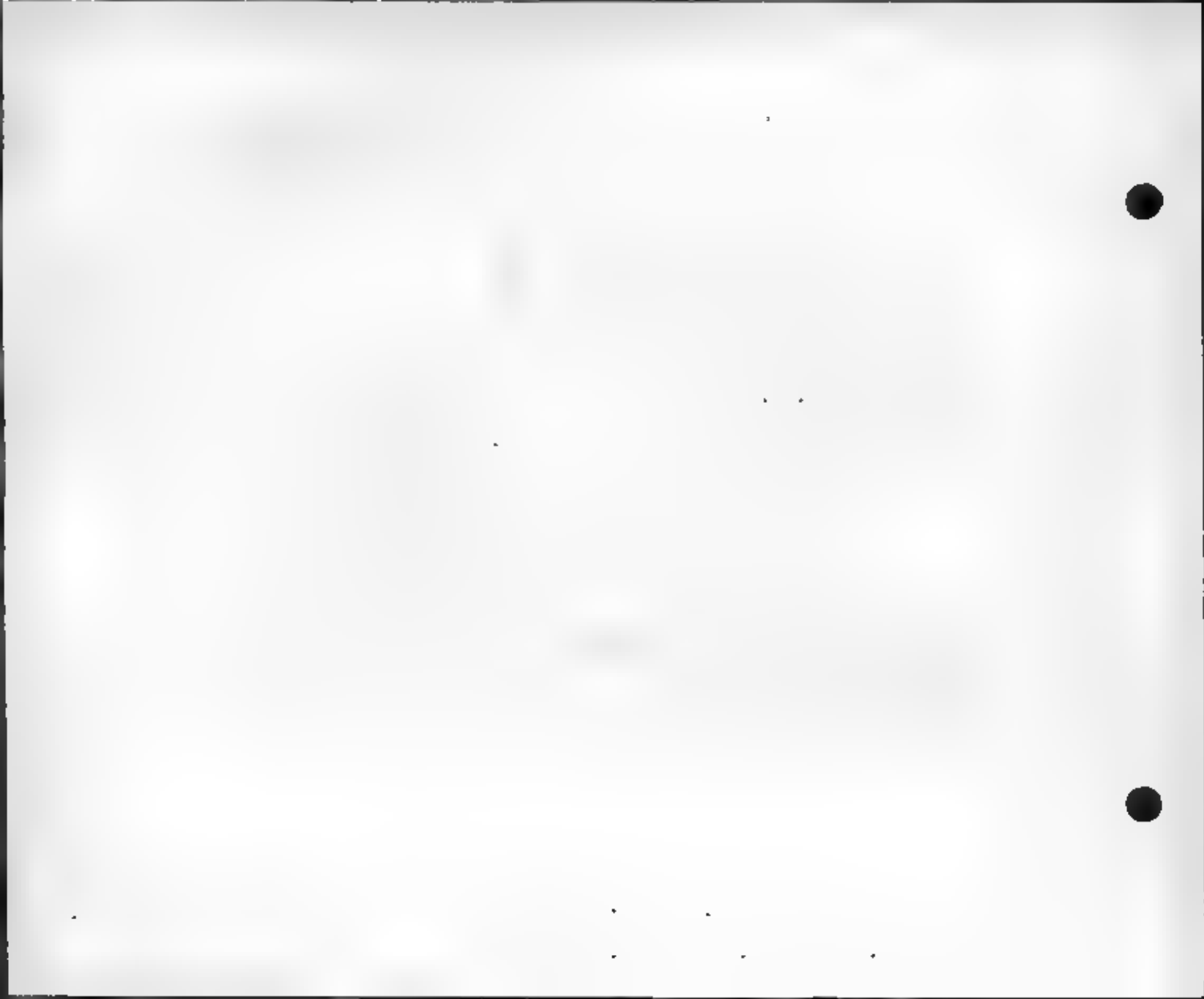
TO **HOSPITAL OR ATTENDING PHYSICIAN:** The **1** requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 1352

27865

1. PLACE OF DEATH a. COUNTY <u>BALTO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>		c. LENGTH OF STAY (In days) <u>32 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McCLEIGH NURSING HOME</u>		e. STREET ADDRESS <u>764 COLDHARFORD RD</u>	
3. NAME OF DECEASED (Type or print) <u>AMY E. KEESE</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/91</u>
9a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. AGE (In years last birthday) Months <u>7</u> Days <u>15</u>	
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>S. J. Campbell</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Fletcher</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214 24 2101</u>		17. INFORMANT <u>Mrs. Doris Kahler</u> Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <u>Acute myocardial infarction</u> <u>Arteriosclerosis</u> DUE TO (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour <u>a.m.</u> <u>10</u> P.M. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u>	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>67</u> to <u>6/24</u> , 19 <u>67</u> that (2) (we) last saw the deceased alive on <u>6/23</u> , 19 <u>67</u> and that death occurred at <u>9</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>6/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>		22d. ADDRESS <u>[Address]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THIRTEEN <u>6/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Holly Cemetery</u>	23d. LOCATION (city, town or county) (State) <u>Remington, Virginia.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

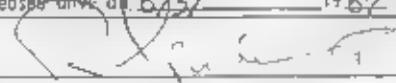
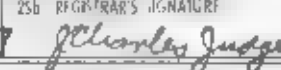


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

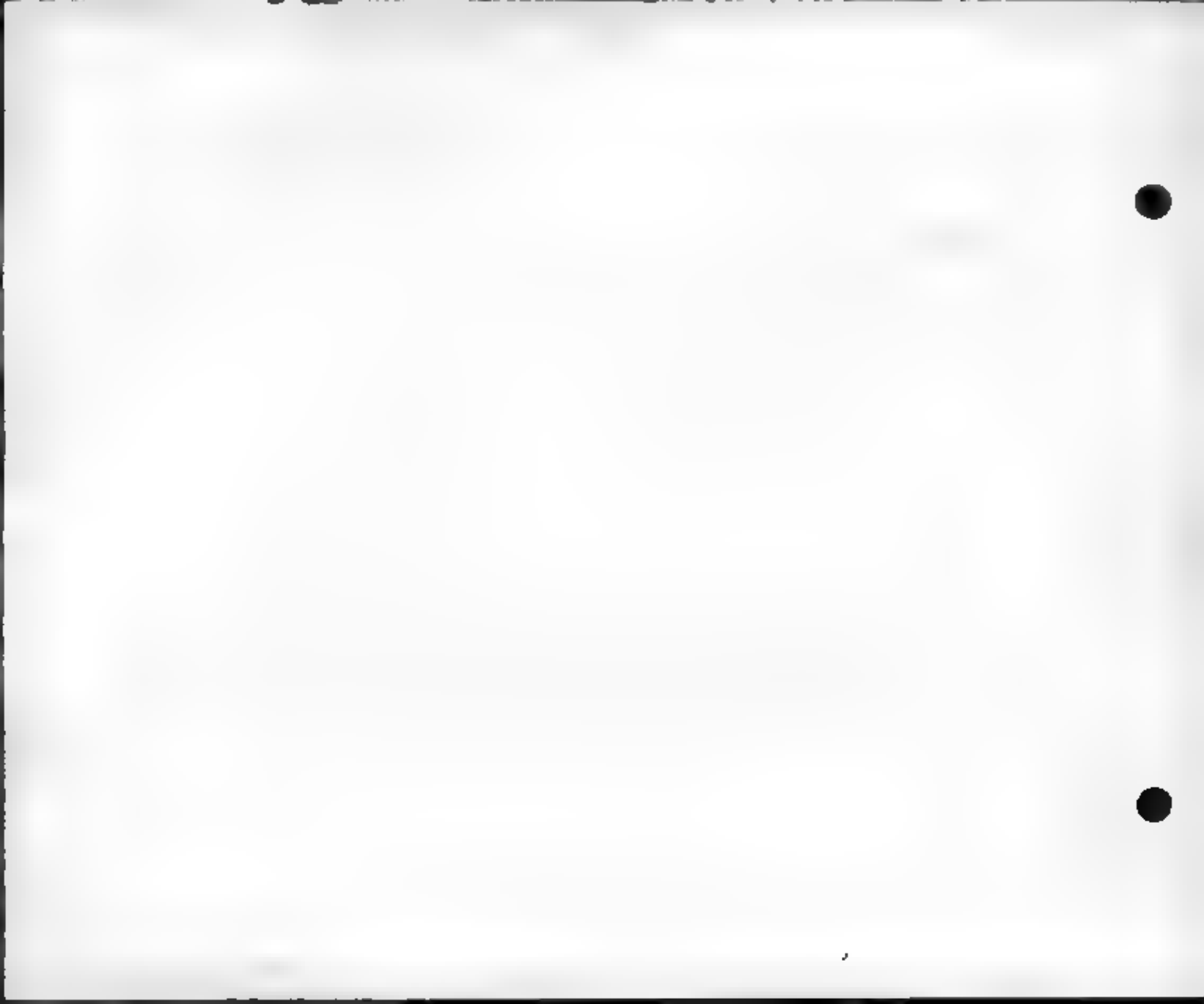
07870

CERTIFICATE OF DEATH

12553

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a COUNTY Maryland b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 1459 Towson St.	
3 NAME OF DECEASED (Type or print) Frank R. Reichenberg		4 DATE OF DEATH Month 6 Day 3 Year 1967	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/27/1918
9 AGE (in years, months, days) 49		10 IF UNDER 1 YEAR Months 4 Days 7 Hours 1 Min 0	
11a OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		11b KIND OF BUSINESS OR INDUSTRY Longshoreman	
12 BIRTHPLACE (County & state or foreign country) Baltimore, Md.		13 COUNTRY OF BIRTH U.S.A.	
14 FATHER'S NAME Frank A. Reichenberg		15 MOTHER'S MAIDEN NAME Mary Wolf	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown, fill in yes, give dates of service) Yes		17 INFORMANT Address Mrs. Emma Wagner 1315 Cooks St.	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laennec's Cirrhosis Conditions, if any, which gave rise to immediate cause (b) DUI TO storing the underlying cause (c) DUI TO			
19 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Pulmonary edema			
20a a. INJURY WAS A FATAL INJURY OR A CONTRIBUTING CAUSE OF DEATH? IF YES, NOTIFY MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY Home, farm, factory, street, office, bldg, etc.		20f CITY or town (County) (State)	
21 I certify that (a) this hospital attended the deceased from 5/31/1967 to 6/3/1967 that we last saw the deceased alive at 6/3/1967 and that death occurred at 5:05 PM from causes and on the date stated above.			
22a SIGNATURE 		22b DATE SIGNED 6-4-67	
22c PHYSICIAN'S NAME (Type) Reynaldo F. Orjuela-Gomez, M.D.		22d ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a BURIAL REMOTION (Specify location)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town, County, State)
Burial	6/7/67	Holy Cross Cemetery	Baltimore, Md.
24 FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 East Port Avenue		25a REC'D BY REGISTRAR JUN 5 1967	25b REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transmittal. Then please file this certificate in the State Department of Health. This should be filed with the State Department of Health. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL, OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove a burial folder. Pages 1 and 2 should be filed with the State Dept of Health. Page 3 should be filed with the State Dept of Health. Page 4 should be filed with the State Dept of Health.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07871

CERTIFICATE OF DEATH

07853

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (When deceased lived in institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		e. STREET ADDRESS 3820 Roland Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Mrs. Edith Remare		4 DATE OF DEATH Month Day Year 6 30 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-31-91
9 AGE in years, months, and days 75 yrs		10 IF UNDER 24 HRS. Hour Min 75	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		11b. KIND OF BUSINESS OR INDUSTRY White Hall, Maryland	
12 FATHER'S NAME Samuel Black		13 MOTHER'S MAIDEN NAME Alice (Black) Duncan	
14a. DECEASED DYED IN U.S. ARMED OR NAVAL SERVICE (Yes, no, or unknown) (If yes, give war or dates of service) ?		14b. SOCIAL SECURITY NO 220444215	
15 INFORMANT Hospital Records		Address	
16 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 110X Metastatic Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (b) a. 110X b. 110X c. 110X d. 110X e. 110X f. 110X g. 110X h. 110X i. 110X j. 110X k. 110X l. 110X m. 110X n. 110X o. 110X p. 110X q. 110X r. 110X s. 110X t. 110X u. 110X v. 110X w. 110X x. 110X y. 110X z. 110X		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE (CONDITION GIVEN IN PART I) Arteriosclerotic Cardiovascular Disease		17a. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
18a. DATE OF INJURY Month Day Year Hour a.m. p.m. 6/20 1967		18b. INJURY OR RISK While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19a. PLACE OF INJURY Home Farm Factory Street Office Bldg. etc. Home		19b. TIME OF INJURY Hour Min 11:40	
20a. CERTIFY THAT (this hospital) attended the deceased from 6/20 1967 to 6/30 1967 and that the deceased died on the date stated above		20b. DATE SIGNED 7-1-67	
21a. SIGNATURE John E. Adams M.D.		21b. ADDRESS Greater Baltimore Medical Center	
22a. PHYSICIAN NAME Type John E. Adams, M.D.		22b. ADDRESS Greater Baltimore Medical Center	
23a. BURIAL REMOVAL (Specify) Burial		23b. DATE THEREOF July 3, 67	
24a. NAME OF FUNERAL HOME OR R. MATORY St. James Episcopal		24b. ADDRESS Monkton, Md. Balto. Md.	
25a. NAME OF FUNERAL HOME OR R. MATORY St. James Episcopal		25b. ADDRESS Monkton, Md. Balto. Md.	
26a. NAME OF REGISTRAR Wm. Cook-Brooks Towson, Towson, Md.		26b. DATE JUL 6 1967	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #15 Film #G314

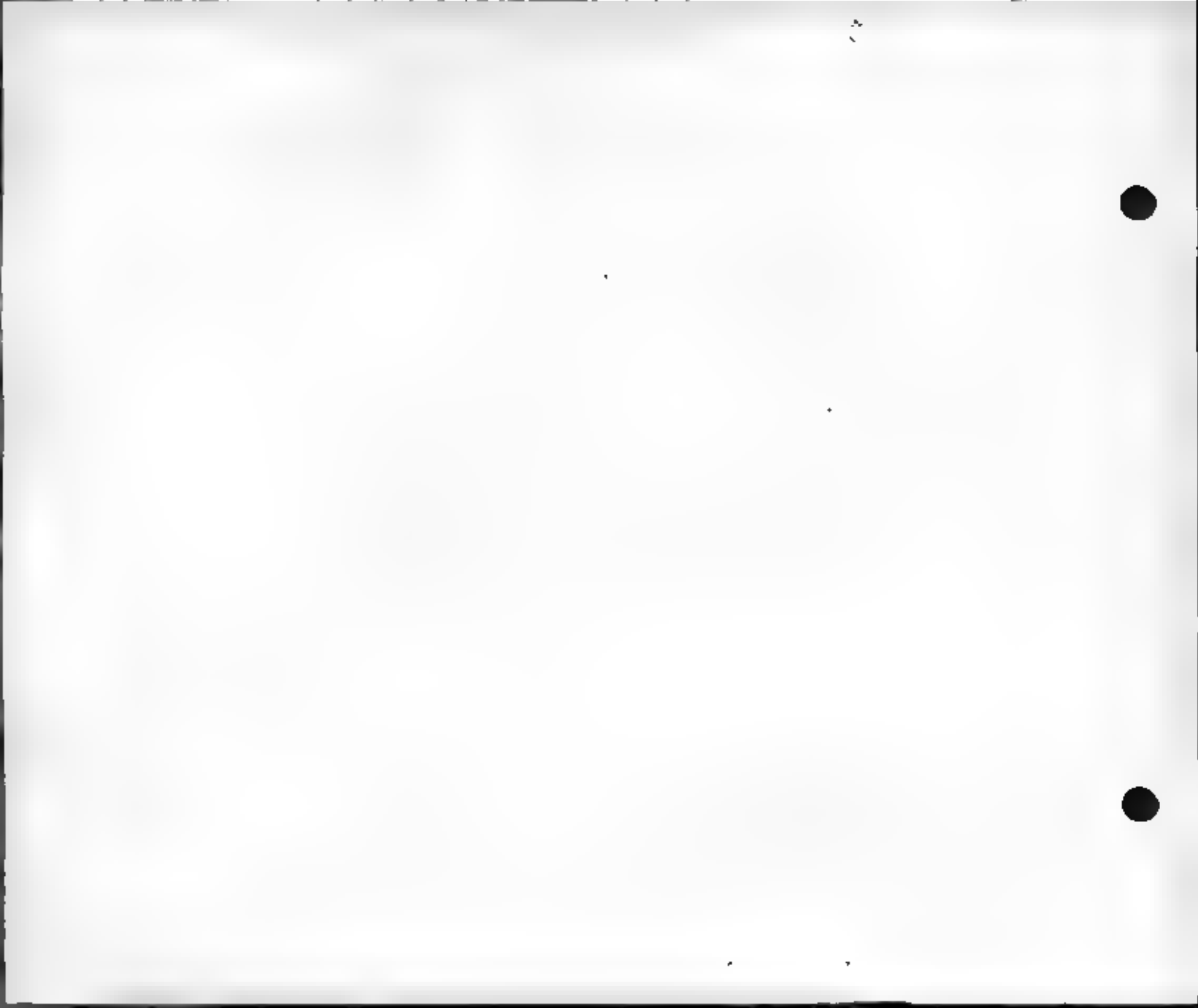
27872

CERTIFICATE OF DEATH

27855

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lowsen c LENGTH OF STAY IN b 10 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Parkville c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 1719 Forrest Ave. #34 d STREET ADDRESS 1719 Forrest Ave. #34 e IF RESIDENT ON A FARM? Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John W. Ricks, Sr. 4 DATE OF DEATH Month June Day 14 Year 1967		5 SEX Male 6 COLOR OR RACE White 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH March 7, 1917 9 AGE (In years) 50 10 FUNDING YEAR 1967 11 INDEX 4 HRS. 4	
12a TYPE OF OCCUPATION (Give kind of work done during most of working life ever or retired) Bus Driver 13b KIND OF BUSINESS OR INDUSTRY Balto. Transit Co 14 BIRTHPLACE (County and State or foreign country) Maryland 15 CITIZEN OF WHAT COUNTRY? USA		16 FATHER NAME Robert L. Ricks 17 MOTHER'S MAIDEN NAME Daisy Waldron	
18 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 19 LOCAL SECURITY NO 213037128		20 INFORMANT Mrs. Charlotte V. Ricks - Same Address:	
B CAUSE OF DEATH (List only one cause per line (line a, b, and c)) PAR I DEATH WAS CAUSED BY IMMEDIATE CAUSE: CORONARY OCCLUSION DUE TO CONDITIONS: (Only which gave rise to immediate cause of death, stating the underlying cause) a CORONARY INSUFFICIENCY b CORONARY c ARTERIO-SCLEROTIC HEART DISEASE PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PAR I) None		INTERVAL BETWEEN ONSET AND DEATH 22 hrs 44 yrs 44 yrs 19 WAS Aopsy PERFORMED? Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
20a IDENTIFY WAS UNDER "Y" OR CONTRIBUTING CAUSE OF DEATH (If neither, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Chief nature of injury in Part I or Part II of item B) 20c TIME OF INJURY Month Day Year Hour 9 PM 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY Home, farm, factory, street, office bldg, etc. 20f City or town 20g State		21 I certify that (this hospital attended the deceased from Feb 2 1963 to June 14 1967 that we last saw the deceased alive on June 12 1967 and that death occurred at 11 M from causes and on the date stated above 22a SIGNATURE Randolph H. Spitzberg MD 22b PHYSICIAN'S NAME (Type) RANDOLPH H. SPITZBERG MD 22c ADDRESS 338 W PRATT ST 22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. CHIEF OR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22e DATE SIGNED 6-14-67	
23a BURIAL REMOVAL (Specify) Burial 23b DATE OF BURIAL 6/17/67 23c NAME OF CEMETERY OR REMOVAL Lorraine Park Cemetery 23d LOCATION (City or town) (County) (State) Baltimore, Maryland		24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. Balto. 25a REC'D BY REGISTRAR DATE JUN 14 1967 25b REGISTRAR SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be retained for use as the burial transcript. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07873

07556

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. OR TOWN If outside corporate limits, write RURAL and give nearest town <u>Crofters Hill</u>		2. USUAL RESIDENCE (where deceased lived if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. OR TOWN If outside corporate limits, write RURAL and give nearest town <u>Crofters Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address <u>Rosewood State Hospital</u>		e. STREET ADDRESS <u>RFD #1</u> f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED Type of print: <u>Bartara Lynn Rader</u>		4. DATE OF DEATH Month: <u>June</u> Day: <u>3</u> Year: <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-66</u>
9. AGE In years, months, days, hours, minutes 10. IF UNDER 1 YEAR: Month: <u>11</u> Day: <u>2</u> Hour: <u>4</u> Min: <u>5</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Chesterton Maryland</u>	
12. FATHER'S NAME <u>Charles Wm. Rider</u>		13. MOTHER'S MAIDEN NAME <u>Chance</u>	
14. DECEASED EVER IN ARMED FORCES? (Yes or no; if yes, give war or date of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>Rosewood Records</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PAR: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral insufficiency</u> 2X DUE TO <u>Internal Hydrocephalus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause to it: <u>Congenital</u>		17. INTERVAL BETWEEN ONSET AND DEATH <u>Congenital</u>	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If "HER NOTIFY MEDICAL EXAMINER")		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: <u>19</u> min: <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> to <u>6-3</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>67</u> and that death occurred at <u>3:30</u> A.M. from causes and on the date stated above			
22a. SIGNATURE <u>Richard A. Jones</u> M.D.		22b. DATE SIGNED <u>3 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones</u>		22d. ADDRESS <u>Rosewood State Hospital</u>	
23a. BURIAL REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 5</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		23d. LOCATION (City or town) (County) (State) <u>MD.</u>	
24. FUNERAL DIRECTOR <u>Edgar Love Church Hill Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please attach the carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial or cremation or removal, and no event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27874

37857

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and sent to the funeral home. The funeral home should be filled with the State Department of Health prior to burial, cremation or entombment and no later than 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		7 USUAL RESIDENCE Where deceased lived if in city or Residence before admission b CITY BALTIMORE MARYLAND	
b CITY OR TOWN (If inside corporate limits write RURAL and give nearest town) BALTIMORE		c CITY OR TOWN (If inside corporate limits write RURAL and give nearest town) BALTIMORE	
d NAME OF HOSPITAL OR CLINIC (If not in hospital give street address) GREATER BALTIMORE MEDICAL CENTRE		e STREET ADDRESS 3511 CANTERBURY RD. APT 304	
1 NAME OF DECEASED First Middle Last ANNIE REBECCA RILEY		4 DATE OF DEATH Month Day Year JUNE 10 1967	
5 SEX FEMALE	b COLOR OR RACE CAU	c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-5-89
10a KIND OF OCCUPATION (Give kind of work done during life or working life even if retired) NONE		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (last birthday) 78 years
3 FATHER'S NAME CHARLES BENJAMIN TITLOW		14 MOTHER'S MAIDEN NAME ANNIE REBECCA MCQUILKIN	
11a DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes give war or dates of service) NO		11b SOCIAL SECURITY NO 220-44-2928	
8 CAUSE OF DEATH (Enter only one cause per line for a, b, c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE a UREMIA, HYPOKALEMIA		15 EVALUATION 75% AND H&H	
b CONDITIONS (any which gave rise to immediate cause or stating the underlying cause) ARTERIOSCLEROTIC VASCULAR DISEASE			
PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVES A PARTIAL YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a a) DEATH WAS UNDERLYING 1 OR ON RIP 1 IN 1 AUC, + DEATH IF OTHER NOTIFY MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OR DISEASE ENTERED NATURE OF INJURY IN PART I OR PART II OF PART 8	
20c TIME OF INJURY Month Day Year Hour: min p.m. 5/17 1967		20d INJURY OR DISEASE While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY Home farm factory street other body etc. HOME
21 certify that this hospital attended the deceased from 5/17 19 67 to 6/10 19 67 that I, we, us, saw the deceased alive on 6/10 19 67 and that a death occurred at 9:05 A.M. from causes and on the date noted above		22b DATE SIGNED 6/10 1967	
22c SIGNATURE Evelyn L. Ramos		22d ADDRESS GAME TOWN 4, MD.	
23a RURAL OR NATIONAL REMOVAL SPECIFY BURIAL		23b DATE THEREOF 6/13/67	
23c NAME OF FUNERAL HOME OR REMOVAL ADDRESS Lloyd Kidge Cem		23d LOCATION (city or town) county state BALTO CO	
24 FUNERAL DIRECTOR Ritchell-Wissegeld		25 BY DAY SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: At the time this certificate is being signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 direct page 3 should be detached to use as the basis for transcription. Health prior to burial, cremation or removal, and in any event within 72 hours after death, should be filed with the State Department of Health.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07875

CERTIFICATE OF DEATH

07853

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived if different from residence before admission) a. STATE DISTRICT OF COLUMBIA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 627 13th STREET, N.E.		f. IF DECEASED IN A HOME, ON A FARM, OR IN A PLACE OTHER THAN A HOSPITAL, GIVE NAME OF PLACE AND ADDRESS	
3. NAME OF DECEASED Type of name First Middle Last WYATT ROBINSON		4. DATE OF DEATH Month Day Year JUNE 13 1967		5. SEX MALE	
6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year SEPT. 10, 1906 60	
9. OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10. DE. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Write & state of foreign country) MONTGOMERY, ALABAMA	
12. FATHER'S NAME WYATT ROBINSON		13. MOTHER'S MAIDEN NAME VIOLE BEAMAN		14. COUNTRY OF BIRTH U.S.A.	
15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW II		16. SOCIAL SECURITY NO. 424 18 37 09		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). a. IMMEDIATE CAUSE OF DEATH CONGESTIVE HEART FAILURE b. AORTIC STENOSIS c. ARTERIOSCLEROTIC HEART DISEASE d. PULMONARY EMPHYSEMA e. PLEURAL EFFUSION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease, condition given in part 18) PULMONARY EMPHYSEMA. PLEURAL EFFUSION					
20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 18 at Part 19 at time of death) a. TIME OF INJURY Month Day Year b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) c. CITY OR TOWN d. STATE					
21. I certify that this certificate was attended the deceased from 5/28/67 to 6/13/67 and that death occurred at 7:35 AM on 6/13/67 from causes and on the date stated above.					
22. SIGNATURE OF PHYSICIAN JOHN D. TALBERT, M.D. 23. ADDRESS VAH FORT HOWARD, MARYLAND					
24. BURIAL a. NAME OF CEMETERY OR CREMATOR LODEN PARK NATIONAL b. ADDRESS BALTIMORE, MD. c. NAME OF FUNERAL HOME WILSON FUNERAL HOME d. ADDRESS ORLEANS ST. BALTIMORE, MD.					



TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please make carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

07876

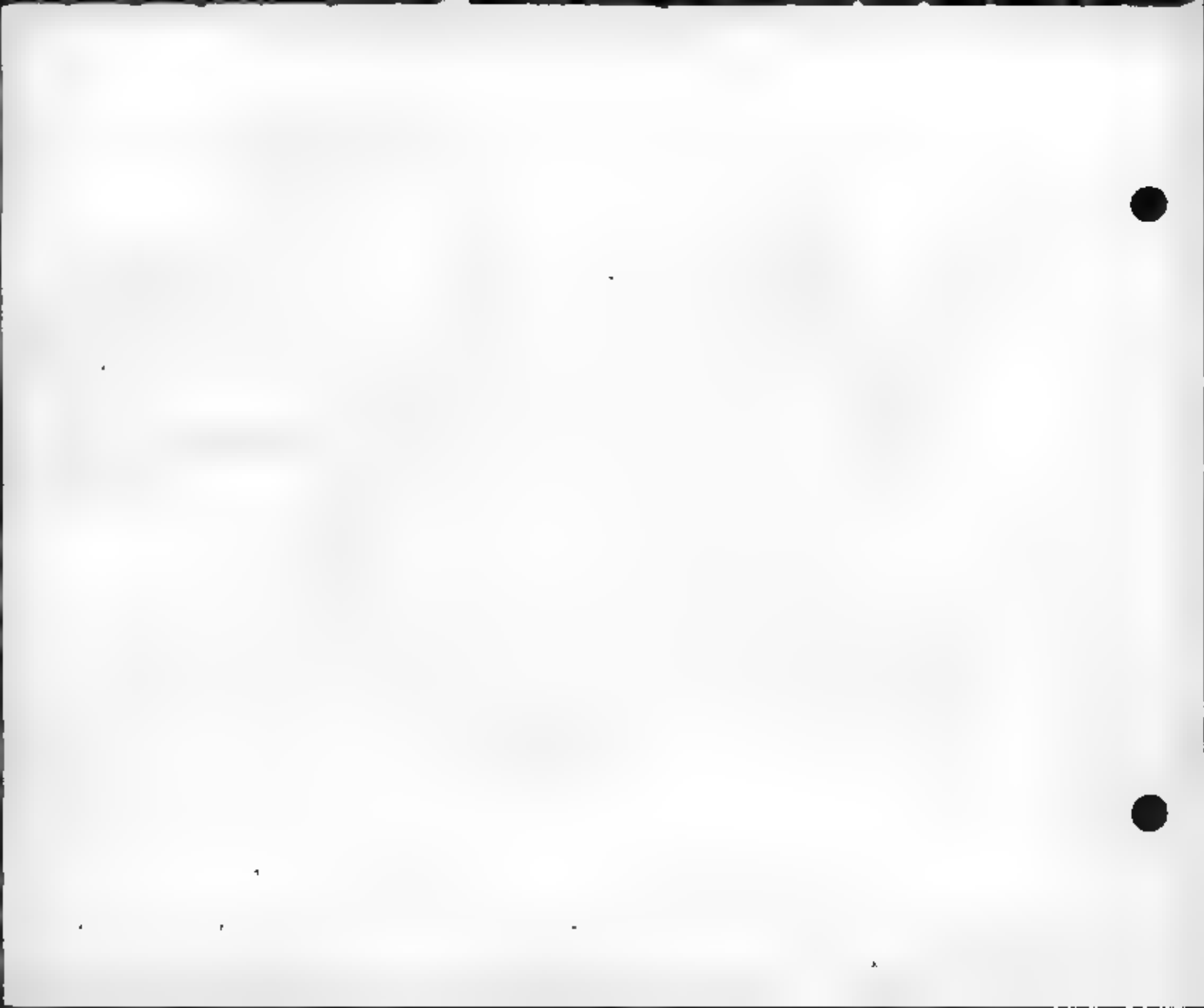
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07853

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) White Marsh				c. LENGTH OF STAY IN 10 18 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 979A Loreley Beach Road				e. STREET ADDRESS Box 979A Loreley Beach Rd			
3. NAME OF DECEASED (Type or print) Roberta L. Rommel				4. DATE OF DEATH June 20 1967			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH March 9, 1905	
9. AGE (In years last birthday) 62 yrs.		10. FUNDING YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZENSHIP OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William E. Murry				14. MOTHER'S MAIDEN NAME Lydia Coale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service No				16. SOCIAL SECURITY NO 24 10 3798			
17. INFORMANT Mrs. Richard Rupp				Address Box 979A Loreley Road White Marsh, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cut at 1-4-67 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO PART II OTHERS ON F. CANT CONDIT. ON CONDIT. BUT NOT TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONING VEN. IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CON. F. BUILDING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED. CAL. EXAM. NER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 to 1967 that (I) (we) last saw the deceased alive on 1967 and that death occurred at 7:12 M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Rumberg				22b. DATE SIGNED 6/21/67			
22c. PHYSICIAN'S NAME (Type) Dr. Rumberg				22d. ADDRESS 805 Fuselage Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) (State) Taylor Ave., Balto., Md.	
24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy, Balto., Md.				25a. REC'D BY REG. STR. (25b. REGISTRAR'S SIGNATURE) JUN 26 1967			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER
Necessary to be executed by the
the funeral director or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be returned for your files
TO FUNERAL DIRECTOR
May be used to remove and in any event within 72 hours after death
May be used to remove and in any event within 72 hours after death

VR A SMC (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

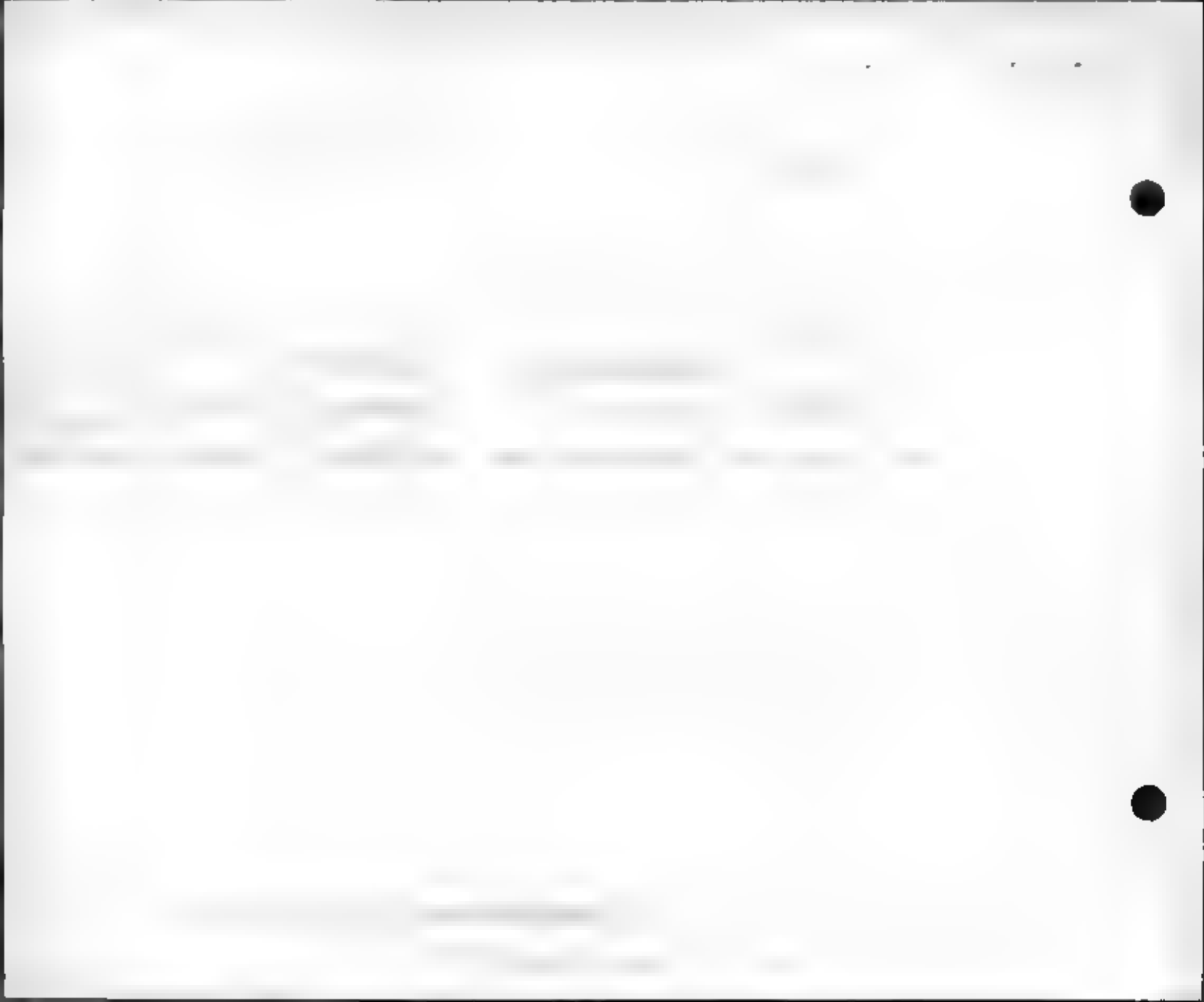
07877

07-60

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		USUAL RESIDENCE Where deceased lived if not in residence as before death b STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN If outside appropriate limits write R. R. No. and give nearest town <u>Woodlawn</u>		c CITY OR TOWN If outside appropriate limits write R. R. No. and give nearest town <u>Woodlawn</u>	
d NAME OF HOSPITAL OR INMATE If not in hospital, give street address		e STREET ADDRESS <u>1919 Winder Rd</u>	
1 NAME OF DECEASED (Type in print) <u>John Maximilian Russell</u>		4 DATE OF DEATH Mo. <u>6</u> Day <u>15</u> Year <u>1967</u>	
2 SEX <u>M</u> b COLOR OR RACE <u>W</u> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b AGE AT BIRTH <u>57 1/2</u> 47		9 AGE WHEN DECEASED Month <u>4</u> Day <u>15</u> Year <u>1967</u>	
c OCCUPATION (If kind of work done during most of working life ever referred) <u>Machine Shop</u>		d BIRTHPLACE (State or foreign) <u>Germany</u>	
3 OTHER NAME <u>Charles Russell</u>		e MOTHER'S MAIDEN NAME <u>Agnes Gunther</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <u>yes</u> No <u>no</u> <u>W.W.II</u>		16 U.S.A. SERVICE NO. <u>21218/5158</u> Mr. Ed. Russell	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE <u>Gunshot Wound Right Temple</u> DUE TO <u>Self Inflicted</u>		18 ADDRESS <u>308 N. Capitol St. Baltimore, Md.</u>	
19 PRIMARY <input type="checkbox"/> OF ENTRIAL NO. <input type="checkbox"/>		20 WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>	
21 I certify that the death of the person named above was caused by <u>Accident</u> [] <u>Horrible</u> [] <u>Undetermined manner</u> []		22 DATE SIGNED <u>6/19/67</u>	
ACTUAL SIGNATURE <u>Ralph E. Updike MD</u>		23 SIGNATURE OF EXAMINER <u>1311 Francis Ave Baltimore Md 21227</u>	
24 SIGNATURE OF REGISTRAR <u>A. V. Singleton</u>		25 SIGNATURE OF REGISTRAR <u>John Burmick MD</u>	

JUN 22 1967

John Burmick MD



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 only

07878

CERTIFICATE OF DEATH

07861

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Catonsville c. STATE Maryland		USUAL RESIDENCE (Where deceased lived if institution) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. STREET ADDRESS 1214 Burnside Drive	
2. NAME OF DECEASED (Type or print) John E. Rutledge		4. DATE OF DEATH June 1 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901
9. AGE 66 years 10 months 10 days		10. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11a. US. (or ALIEN) PATIENT (Give kind of work done during past year or working life even if retired) Acct.		11b. KIND OF BUSINESS OR INDUSTRY N.Y. City	
12. FATHER'S NAME Michael Rutledge		13. MOTHER'S MAIDEN NAME Mary Gallager	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		15. SOCIAL SECURITY NO. 1-1-1-1-1-1-1-1-1-1	
16. INFORMANT John E. Rutledge JR, 1214 Burnside Dr.		17. ADDRESS 1214 Burnside Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Cancer of mouth b. Parkinson's dis. c. 1 year		19. MEDICAL CERTIFICATION 20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 21. TIME OF INJURY Month, Day, Year June 1 1967 22. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> 23. PLACE OF INJURY (Home form for home, office, etc.) Home 24. (City or town) (County) (State) Brooklyn New York	
25. SIGNATURE John E. Rutledge JR		26. DATE SIGNED June 2/67	
27. PHYSICIAN'S NAME (Type) Howard H. Hubbard		28. ADDRESS 4107 Wilkens Ave. 21229	
29. DATE OF DEATH June 1 1967		30. LOCATION (City or town) (County) (State) Brooklyn New York	
31. RECD BY REGISTRAR June 5 1967		32. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 + 64

1 **FOR STATE HEALTH DEPT.**

1-6-2 21 Film 3-7

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17862

1 PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Parkton
c. LENGTH OF STAY IN b. minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 83

2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE Penn
b. COUNTY Dauphin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisburg, Penn
d. STREET ADDRESS 4602 North Rd.

3 NAME OF DECEASED (Type or print) Edmund F. Ryan, Jr.
First Middle Last
4. DATE OF DEATH June 24 1961
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Febr. 22, 1947 9. AGE in years 14 IF UNDER 1 YEAR IF UNDER 24 HRS. (last birthday) Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) Student 10b. KIND OF BUSINESS OR INDUSTRY College 11. BIRTHPLACE (State or foreign country) Harrisburg, Penna. U.S.A. 12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME Edmund F. Ryan, Sr. 14. MOTHER'S MAIDEN NAME Catherine Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 193-36-3944 17. INFORMANT Edmund F. Ryan, Sr. Address 4602 North Rd., Harrisburg, Penna.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a).
DUE TO
PART 2 OTHERS OR FURTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Automobile struck a
CAUSE OF DEATH car
20c. TIME OF INJURY Month Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, to m. factory, street, etc.) Home 20f. City or town Harrisburg Country Baltimore State M.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspect on ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Indetermined manner ☐

ACTUAL SIGNATURE C. H. Franke 22. DATE SIGNED 6/24/61
EXAMINER'S NAME (Type) A. H. Franke
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify) Burial 23b. DATE THEREOF 6-27-61 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem 23d. LOCATION (City, town, or county) (State) Harrisburg, Dauphin Co., Pa.

24. FUNERAL DIRECTOR Samuel Kastenstien ADDRESS New Freedom, Pa. 25a. REC'D BY REG. S. H. II Charles Judge 25b. HONSTRATED S. H. II JUN 29 1961



TO DEPUTY MEDICAL EXAMINER

The report should be forwarded to the Chief Medical Examiner's Office or to the State Department of Health prior to burial, cremation, or removal of the body.

Page 4 should be forwarded to the Chief Medical Examiner's Office or to the State Department of Health prior to burial, cremation, or removal of the body.

FOR STATE HEALTH DEPT.

VR A 54E 3
6M 67

TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. The pages 1 and 2 of the State Department of Health prior to burial, cremation, or removal of the body.

<p>MARYLAND AND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p>			
<p>07890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07893</p>			
<p>1 PLACE OF DEATH Baltimore Catonsville 6110 Edmondson Avenue</p>		<p>2 USUAL RESIDENCE (Where deceased lived if institution Reside) Maryland Baltimore Catonsville 6110 Edmondson Avenue</p>	
<p>3 NAME OF DECEASED (Type of print) ALFRED EUGENE SCANLON Male White Married Type of occupation Linotype Operator FATHER'S NAME William S. Scanlon</p>		<p>4 DATE OF DEATH June 20, 1967 9-15-24 Pennsylvania MOTHER'S MAIDEN NAME Irene W. Murphy</p>	
<p>5 CAUSE OF DEATH Barbiturate Overdose 1/10 32 DUE TO Conditions, if any, which gave rise to the underlying cause Barbiturate Overdose</p>		<p>6 TIME OF DEATH 11:00 PM PLACE OF DEATH Catonsville, Pa.</p>	
<p>7 I certify that I took charge of the person described above and died of a sudden death resulting from a natural cause.</p>		<p>8 I certify that I took charge of the person described above and died of a sudden death resulting from a natural cause.</p>	
<p>9 ACTUAL SIGNATURE Werner U. Spitz, M.D.</p>		<p>10 DATE SIGNED 6/20/67</p>	
<p>11 BURIAL 6-21-67</p>		<p>12 OUR LADY OF GRACE Langhorne, Penna.</p>	
<p>13 FUNERAL HOME Wm. Cook-Brooks Inc. 1217 St. Paul St. Baltimore, Maryland</p>		<p>14 JUNE 26 1967</p>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27881

67361

1 PLACE OF DEATH a. COUNTY BALTO		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RANJAL TOWN		2 USUAL RESIDENCE (Where deceased lived if institution. If none, see below) a. STATE MARYLAND b. COUNTY BALTO	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO COUNTY GEN HOSP		d. STREET ADDRESS 809 JUDY LANE		e. IS RESIDENCE ON A "ARM"? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ELIZABETH ANNE SCHAEFER		4 DATE OF DEATH Month 6 Day 27 Year 1967			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/15/1947	9 AGE in years last birthday 22	10 UNDER 1 YEAR Months 12 Days 12 Hours 12
11a. BIRTH DATE (If none kind of work done during most of working life even if armed) 12/1/47		11b. KIND OF BUSINESS OR INDUSTRY AT HOME		12 BIRTHPLACE (If not in U.S. state or foreign country) MISSOURI MO	
13 FATHER'S NAME MAY KAISER		14 MOTHER'S MAIDEN NAME REBECCA		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 215-09-4434		17 INFORMANT MRS. ANNETTE DEER A.		18 ADDRESS 809 JUDY LANE	
19 CAUSE OF DEATH (Enter only one cause per line for 19a, 19b, and 19c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE to CONDITIONS in any which gave rise to immediate cause a) stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS	
20a. IDENTIFY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER) CHRONIC VASCULAR ACCIDENT				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III at item 18.) HCVD	
21. ME OF INJURY Month Day Year hour am pm 9				22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
23. PLACE OF INJURY Home, farm, factory, street, office, bldg, etc. BALTO COUNTY GEN HOSP				24. CITY or town (County) (State) BALTO MD	
25. I certify that (this hospital) attended the deceased from 10/23/67 to 6/27/67 that (we) last saw the deceased alive on 6/27 19 67 and that death occurred at 1157 PM from causes and on the date stated above					
26a. SIGNATURE Charles H Williams		26b. DATE SIGNED 6/27/67		26c. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
27a. PHYSICIAN'S NAME (Type) CHARLES H WILLIAMS		27b. ADDRESS BALTO COUNTY GEN HOSP			
28a. BURIAL CREMATION, REMOVAL (Specify) CREMATION	28b. DATE THREFO 6/29/67	28c. NAME OF CEMETERY OR CREMATORY ELLSWORTH	28d. LOCATION (City or town) (County) (State) BALTO MD	29a. REC'D BY REGISTRAR JUL 3 1967	
29b. FUNERAL DIRECTOR COL LEVY COV & SONS, INC., 6010 ELIST., CT.		29c. REGISTRAR'S SIGNATURE Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and any other action within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07882

07585

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Essex (21) c. STATE MARYLAND		2. USUAL RESIDENCE Where deceased lived, if institution Residence before admission a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Essex (21)	
3. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address 701 Christian Ave.		d. STREET ADDRESS 701 Christian Ave. e. IS RESIDENCE ON A ARMY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last FRANK SCHARMER		4. DATE OF DEATH Month Day Year June 25, 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1878
9. AGE Years 88 Months 11 Days 19 Hours 11 Minutes 00		10. UNDER 24 HRS. Months 11 Days 19 Hours 11 Minutes 00	
11. USUAL OCCUPATION Give kind of work done during most of working life (even if retired) Farmer		12. KIND OF BUSINESS OR INDUSTRY Farm	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? If yes, no, or unknown (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Scharmer		Address 703 Christian Ave. Balto 21	
18. CAUSE OF DEATH Enter only one cause per line for a, b, and c a. IMMEDIATE CAUSE (a) Circulatory failure b. DUE TO Heart failure, chronic c. DUE TO Arteriosclerotic cardio-vascular disease		19. IN PERIOD BETWEEN DEATH AND DEATH 6 months	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If neither, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
24. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	26. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) None	27. CITY OR TOWN (County) (State) None
28. I certify that (1) (this hospital) attended the deceased from March 24, 1967 to June 25, 1967 that (two) last saw the deceased alive on June 1, 1967 and that death occurred at 12 PM from causes and on the date stated above			
29a. SIGNATURE Eugene C. Baumann M.D.		29b. DATE SIGNED 6-26-67	
29c. PHYSICIAN'S NAME EUGENE C. BAUMANN		29d. ADDRESS 413 EASTERN AVE, BALTIMORE 21	
30. BURIAL CREMATION, REMOVAL, SPECIALTY Burial	31. DATE THEREOF 6/27/67	32. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	33. CITY OR TOWN (County) (State) Baltimore, Maryland
34. FUNERAL DIRECTOR Brazdzinski Funeral Home		35. ADDRESS 1407 Eastern Ave.	
36. REC'D BY REGISTRAR JUN 28 1967		37. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07883

CERTIFICATE OF DEATH

07865

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the funeral director, it should be filed with the State Department of Health prior to burial, cremation or entombment. Pages 1 and 2 should be filed with the State Department of Health within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		2 USUAL RESIDENCE (Where deceased lived if information. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21205	
3 NAME OF DECEASED (Type or print) George Schmid		4 DATE OF DEATH Month June Day 23 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 4, 1898
9 AGE at year last birthday 69 yrs		10 IF UNDER 24 HRS. Months _____ Days _____ Hours _____	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Butcher		11b. KIND OF BUSINESS OR INDUSTRY Heil & Co	
12 BIRTHPLACE (County & State or foreign country) Germany		13 COUNTRY OF WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME Joseph Schmid		15 MOTHER'S MAIDEN NAME Theresa Muller	
16 WAS DECEASED EVER IN ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) no		17 SOCIAL SECURITY NO 2 5-07-0426	
18 INFORMANT Elizabeth Schmid, wife, above		Address: Elizabeth Schmid, wife, above	
19 CAUSE OF DEATH (Enter only one cause per line for a) (b) and c) a. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1641 b. metastatic to brain and liver c. metastatic to brain and liver		INTERVAL BETWEEN ONSET AND DEATH	
20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND CONDITION GIVEN IN PAR 19 Myocardial infarction, acute and old.		21 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or enter 1B.)	
22a. DISTAL UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Myocardial infarction, acute and old.		22b. TIME OF INJURY Month Day Year Hour am pm 19	
23a. INJURY OF IRRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		23b. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home	
24a. CITY OR TOWN Towson		24b. COUNTY Baltimore	
25a. DATE OF DEATH June 23, 1967		25b. TIME OF DEATH 12:15 PM	
26a. SIGNATURE Juana S. Cockburn, M.D.		26b. ADDRESS 7620 York Rd., Towson 21204, Md.	
27a. BURIAL, CREMATION, REMOVAL, etc. Burial		27b. DATE THEREOF 6/26/67	
28a. NAME OF CEMETERY OR REMATORY Gardens of Faith Cem		28b. LOCATION (City or town, county, state) Baltimore, Md.	
29a. NAME OF FUNERAL HOME, INC. Schimunek Funeral Home, Inc.		29b. ADDRESS 3331 Brehms Lane	
30a. RECEIVED BY REGULAR DATE JUN 20 1967		30b. RECEIVED BY SPECIAL Charles Judge	



CERTIFICATE OF DEATH

Reg. Dist. No. 1700

97884

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>76 DUNDALK AVE</u>		d. STREET ADDRESS <u>76 DUNDALK AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM SCHOCK</u>		4 DATE OF DEATH Month Day Year <u>JUNE 27 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 8, 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during major working life, even if retired) <u>TECH. RAIL ATE</u>		9b. HAND OF BUSINESS OR INDUSTRY <u>SHIPYARD</u>	
10. FATHER'S NAME <u>GOTTLEBER SCHOCK</u>		11. MOTHER'S MAIDEN NAME <u>MARIE PFITZEMIER</u>	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		13. SOC. SEC. NO. <u>217-05 5181</u>	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <input type="checkbox"/> Conditions if any which gave rise to immediate cause (a), stating the underlying cause last <input type="checkbox"/> DUE TO <input type="checkbox"/> (c)		15. INFORMANT <u>J. R. SCHOCK</u> Address <u>1217 7th R-15 Baltimore, Md.</u>	
16. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10 1967</u> to <u>June 22 1967</u> , that I last saw the deceased alive on <u>June 27 1967</u> , and the death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard L. Lagan</u>		DATE SIGNED <u>6-28-67</u>	
PHYSICIAN'S NAME (Type) <u>Walter Brooks Broadly, Jr.</u>		ADDRESS <u>59 Dundalk Ave. Balt. Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>6/30/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Co. Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Broadly, Jr.</u>		24a. REC'D BY REGISTRAR <u>1967</u>	
ADDRESS <u>59 Dundalk Ave. Balt. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Judge</u>	



5/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove farban paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or entombment within 72 hours after death.

VA 115 (4)
28 MAR 1966

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

97885

CERTIFICATE OF DEATH

17568

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) d. STATE <u>Maryland</u> e. COUNTY <u>Baltimore</u>	
f. LENGTH OF STAY IN b. <u>1 week</u>		g. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Arbutus</u>	
h. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) <u>Shangri-Lu Nursing Home</u>		i. STREET ADDRESS <u>5110 Arbutus Ave.</u>	
j. NAME OF DECEASED First Middle Last <u>Ernest C. Schoenfelder</u>		k. DATE OF DEATH Month Day Year <u>June 9 1967</u>	
l. SEX <u>Male</u>	m. COLOR OR RACE <u>White</u>	n. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	o. DATE OF BIRTH Month Day Year <u>3-13 28 79</u>
p. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brush Maker</u>		q. JOB KIND OF BUSINESS OR IND. TRY <u>Glass Pittsburgh Plate</u>	r. BIRTHPLACE (County & State or foreign country) <u>Balto. City</u>
s. FATHER'S NAME <u>Henry Schoenfelder</u>		t. MOTHER'S MAIDEN NAME <u>Becky Fisher</u>	
u. VA. DEFENSE MEMBER IN U.S. ARMED FORCES? Yes (If unknown) (If yes give year or dates of service) <u>Yes WWI</u>		v. SOCIAL SECURITY NO. <u>213-05-3068</u>	
w. INFORMANT <u>Margaret J. Schoenfelder</u>		x. ADDRESS <u>5110 Arbutus Ave.</u>	
y. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) (Condition: if any which gave rise to immediate cause (a), stating the underlying cause last.) <u>Acute Myocardial Infarction</u> <u>Hypertensive Cor V. Disease</u>			z. INTERVAL BETWEEN ONSET AND DEATH <u>One Day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Emphysema</u>			
aa. ADJACENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		ab. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)	
ac. ME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	ad. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	ae. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	af. (City or town) (County) (State)
ag. I certify that (this hospital) attended the deceased from <u>June 6</u> 19 <u>67</u> to <u>June 9</u> 19 <u>67</u> that (we) last saw the deceased alive on <u>June 7</u> 19 <u>67</u> and that death occurred at <u>9 P.M.</u> from causes and on the date stated above			
ah. SIGNATURE <u>John K. Weagly</u>		ai. DATE SIGNED <u>June 9 1967</u>	
aj. PHYSICIAN'S NAME (Type) <u>John K. Weagly</u>		ak. ADDRESS <u>Shangri-Lu Nursing Home (Baltimore)</u>	
al. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	am. DATE THEREOF <u>6/13/67</u>	an. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	ao. LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>
ap. FUNERAL DIRECTOR <u>Howard H. Hubbard F. H.</u>		aq. ADDRESS <u>4107 Wilkens Ave.</u>	ar. REC'D BY REGISTRAR <u>Charles Judge</u>
as. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		at. DATE <u>JUN 12 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and page 4, and in any event within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation or removal.

VR A 5 5
25M 6 5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07886

CERTIFICATE OF DEATH

27-69

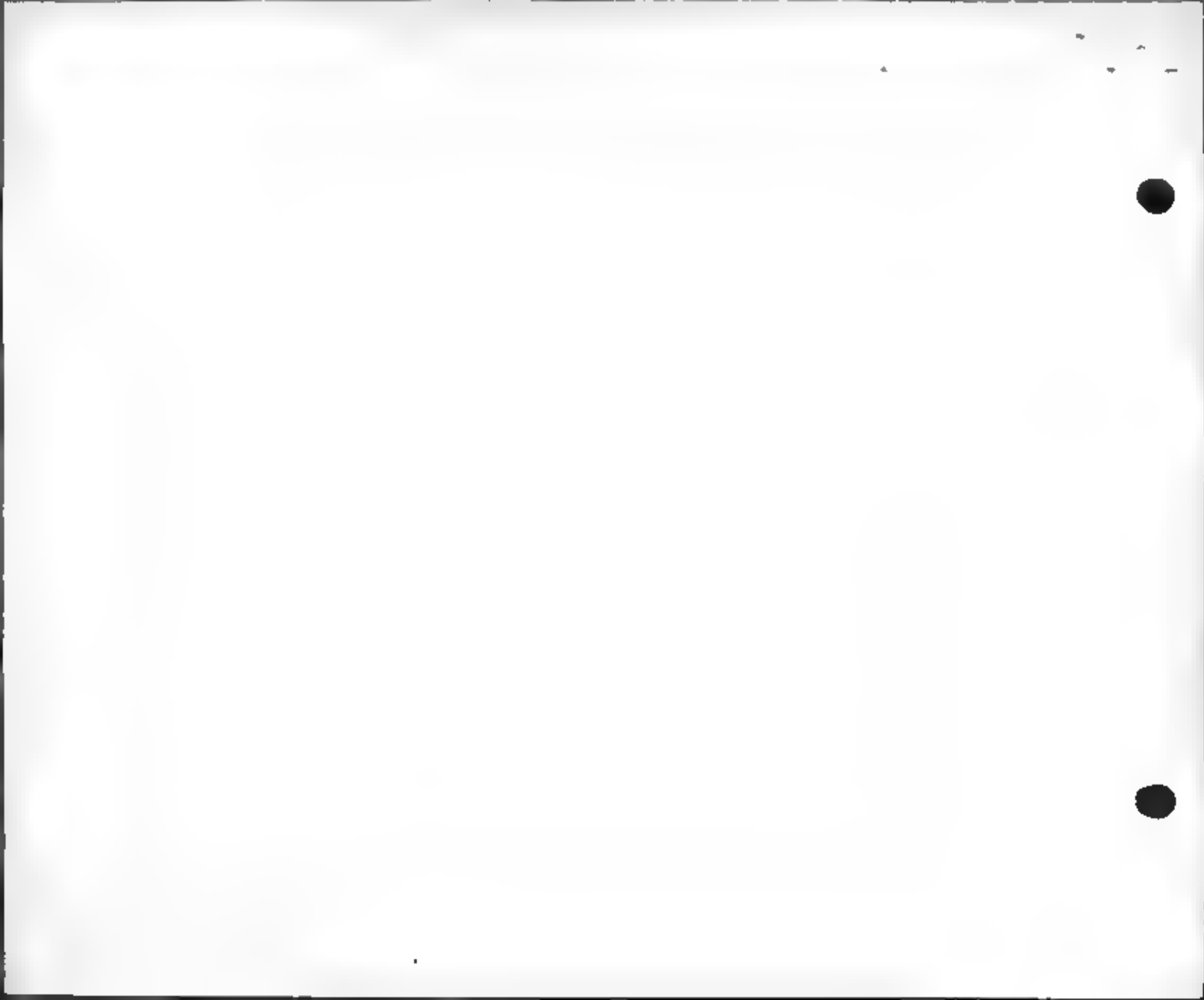
1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN TH MARYLAND		1 USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Route 14, Box 220	
2 NAME OF DECEASED Type or print Virginia Middle Virginia Last SHONE		4 DATE OF DEATH Month June Day 25 Year 1967	
3 SEX female	5 COLOR OR RACE white	6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-31-08
9 AGE (In years, last birthday) 58		10 FINDER YEAR Months June Day 25 Hour 10 Min 00	
11a. OCCUPATION (Give kind of work done during most or working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (Country & State or foreign country) Maryland		13 CITIZEN OF WHAT COUNTRY USA	
3 AIMER'S NAME MAJOR JENKINS		4 MOTHER'S MAIDEN NAME	
5a. WAS DECEASED IN U.S. ARMED FORCES? (Yes, No or unknown. If yes, give war or dates of service) No		6 SOCIAL SECURITY NO -	
7 INFORMANT Wm. H. Schone, Jr.		Address PRC 1	
8 CAUSE OF DEATH (List only one cause per line for each part) PART 1 DEATH WAS CAUSED BY Malignant melanoma IMMEDIATE CAUSE TO 1409 DUE TO 1409 Conditions if any which gave rise to immediate cause for stating the underlying cause 1409 DUE TO 1409 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART 1		IN R.V.A. BETWEEN ONLY 1 AND 3 AT	
20a. IDENTIFY MEDICAL EXAMINER OR INJURY INQUIRY EITHER NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 or item 18.)	
20c. TIME OF INJURY Month Day Year Hour am pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office, hotel, etc.		20f. City or town Baltimore County Baltimore State Md.	
21. I certify that this hospital attended the deceased from June 12 1967 to June 25 1967 the 10 day last saw the deceased alive on June 25 1967 and that death occurred at 9:10 PM on June 25 1967 at the place and on the date stated above.			
22a. SIGNATURE Reynaldo Orjela-Gomez, M.D.		22b. DATE SIGNED June 26, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL REMOVAL, REMOVAL TO	23b. DATE THEREOF 29/67	23c. NAME OF CEMETERY OR REMOVAL	23d. LOCATION (City or town, County, State) MD.
24. FUNERAL DIRECTOR J. S. CARROLL		25a. RECEIVED BY REGISTRAR JUN 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

THIS REPORT ARE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY PLEASE EXERCISE THE EXTENSIVE WRITING THE WORD PENDING IN PENCIL. IF C-VE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. FILE PAGES 2 AND 3 WITH THE STATE DEPARTMENT OF HEALTH OR ITS DESIGNATED AGENT PRIOR TO BURIAL, CREMATION OR REMOVAL AND IN ANY CASE WITHIN 72 HOURS AFTER DEATH.

07887		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		07870	
PLACE OF DEATH COUNTY Baltimore		MAY AND FIGHT OF 1A IN 15		JSMIA. RESIDENCE Where permitted lived in Re. date before death STATE Maryland CITY OR TOWN Baltimore 21234	
TOWNSHIP Towson		NAME OF DECEASED First Middle Last St. Joseph Hospital		DATE OF DEATH Month Day Year June 17, 1967	
NAME OF DECEASED Type of death (Hiram) Harry A. SCHOPPERT		DATE OF BIRTH Month Day Year March 10, 1877		AGE Years Months Days 90	
SEX Male		MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED		RACE White	
OCCUPATION Carpenter		INDUSTRY Lumber Mill		CITY OF BIRTH West Virginia	
FATHER'S NAME Alexander Schoppert		MOTHER'S MAIDEN NAME Mary -		COUNTRY OF BIRTH USA	
DECEASED'S RESIDENCE Yes (No, if unknown) (If yes give ward or dates of service) No		INFORMANT Name Harry E. Schoppert, 8110 Oakleigh Rd.		ADDRESS Balto. Md.	
CAUSE OF DEATH PART 1 Enter only one cause per line for 1a and 1b 1a. IMMEDIATE CAUSE (to be filled in) 1b. DUE TO 1c. DUE TO		INTERVAL BETWEEN DEATH AND EXAMINATION 12 Days		PART 2 OTHER SIGNIFICANT INFORMATION CONTRIBUTING TO DEATH BUT NOT RECORDED IN THE FINAL CAUSE Stroke from Heart Disease	
20a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> ADDITIONAL CAUSE Stroke from Heart Disease		20b. INJURY OCCURRED While at work <input type="checkbox"/> No work <input checked="" type="checkbox"/> Place of injury Home		20c. PLACE OF INJURY Home <input checked="" type="checkbox"/> Factory <input type="checkbox"/> Street <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> Baltimore	
20d. TIME OF INJURY Month Day Year 6/5/67		20e. I certify that I took charge of the remains described above and that the death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. DATE SIGNED 6/17/67	
ACTUAL SIGNATURE EXAMINER'S NAME Charles E. O'Donnell, M.D.		21. NAME OF MINISTRY OR CREMATORY New Cathedral		22. DATE SIGNED 6/17/67	
23a. BURIAL REMOVAL Burial		23b. DATE THEREOF 6-20-67		23c. LOCATION Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Wm. E. Johnson, 8521 Loch Raven Blvd. Balto. Md.		25a. RECEIVED BY REGISTRAR JUN 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and no later than 72 hours after death.

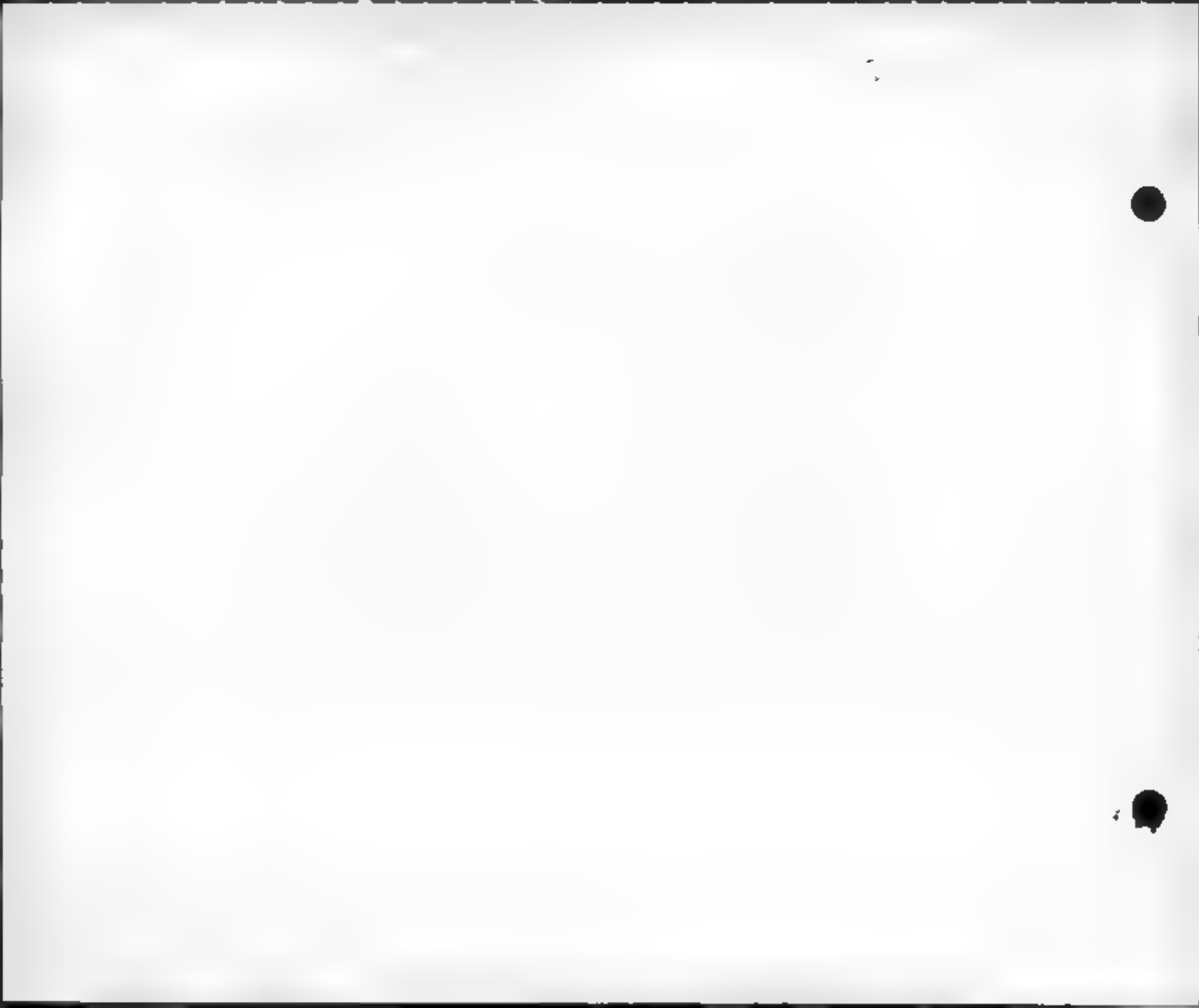
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07888

CERTIFICATE OF DEATH

07871

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN <u>BALTIMORE</u> c. OUTSIDE CORPORATE LIMITS write R.R. and give nearest town <u>NEA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>465 PINE STREET</u>		2 USUAL RESIDENCE (Where deceased lived if in institution or residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u> c. CITY OR TOWN (If outside corporate limits write BUREAU and give nearest town) <u>1304</u> d. STREET ADDRESS <u>303 TALLER AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL M. TALLER</u>		4 DATE OF DEATH Month Day Year <u>JUN 19 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month Day Year <u>SEPT 1 8 1907</u>
9 AGE in years last birthday <u>59</u>		10 IF UNDER 1 YEAR Month Days Hour Min <u>2</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>CLERK</u>		12 KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
13 FATHER'S NAME <u>WALTER DAVID</u>		14 MOTHER'S MAIDEN NAME <u>MARGARET ROSS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>220-4-5745 D-ROTHS MD</u>	
17 INFORMANT <u>76 PERMANENT</u>		Address <u>76 PERMANENT</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1-1</u> CONDITIONS (b) <u>1-1</u> WHICH GAVE RISE TO IMMEDIATE CAUSE (c) <u>1-1</u> AFFECTING THE UNDERLYING CAUSE <u>1-1</u> lost		INTERVIEW BETWEEN ONSET AND DEATH <u>1-1</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>9</u>	20d. INJURY OCCURRED while <input type="checkbox"/> or work <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <u>4/2 1967</u> to <u>6/9 1967</u> that (I) (we) last saw the deceased alive on <u>4/2 1967</u> and that death occurred at <u>9</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. B. T. MD</u>		22d. ADDRESS <u>Longwood Center</u>	
23a. BURIAL OR CREMATION (Specify) <u>CREMATION</u>	23b. DATE OF BURIAL OR CREMATION <u>6/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>REDEEMER</u>	23d. LOCATION (City or town) (County) (State) <u>FALTON MD</u>
24. FUNERAL DIRECTOR <u>G. COOPER</u>		25a. REC'D BY REGISTRAR <u>W. C. MACE</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE <u>JUN 22 1967</u>	



CERTIFICATE OF DEATH

07272

VR A 5 4
25JA '67



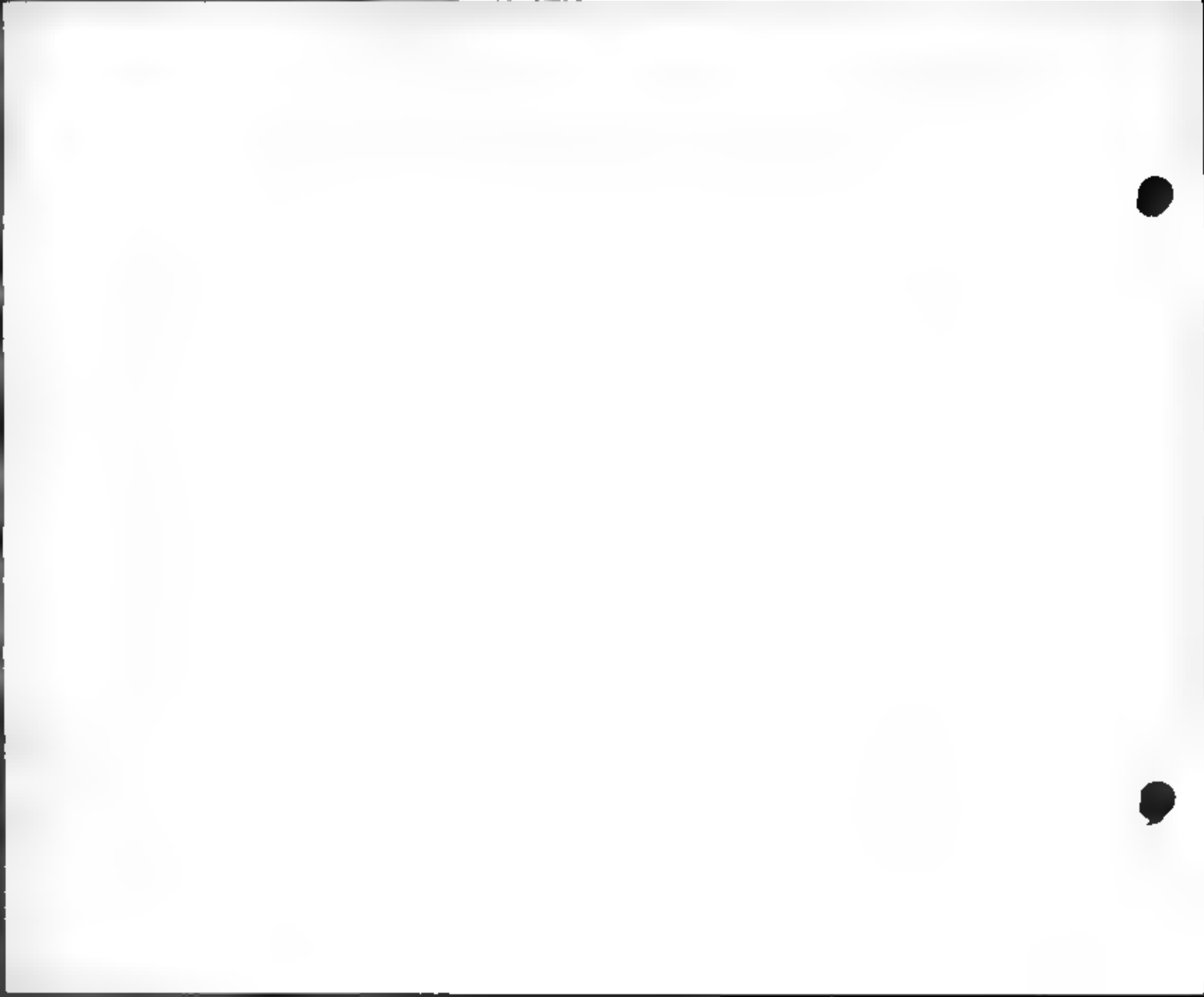
EDR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If death occurs on a day other than the day of the week, the certificate should be executed on the next business day. The certificate should be executed in pencil, in triplicate, and 3 copies should be retained for you. 1 copy should be retained for you, 1 copy should be retained for the funeral director, and 1 copy should be retained for the State Department of Health. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 1 of 2. The State Department of Health, 727 North Avenue, Baltimore, Maryland 21201.

07890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		USUAL RESIDENCE Where deceased lived prior to death Maryland	
DATE OF DEATH 10 years		DATE OF DEATH 6	
NAME OF HOSPITAL OR PLACE OF DEATH Rosewood State Hospital		STREET ADDRESS 619 Mt. Holly St.	
NAME OF DECEASED Catherine		DATE OF DEATH Dec. 28, 1941	
SEX Female		AGE 25	
RACE Negro		DATE OF BIRTH Dec. 28, 1941	
MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOW		DATE OF DEATH Dec. 28, 1941	
OCCUPATION none		BIRTHPLACE USA	
FATHER'S NAME Raymond Scott		MOTHER'S MAIDEN NAME OWENS, Louise	
No		Rosewood Records, Owings Mills, Md.	
1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY Asphyxia due to aspiration of food.			
INTERVAL BETWEEN ONSET AND DEATH 10-minutes.			
CONDITIONS, if any, which gave rise to immediate cause of death Epilepsy, Blindness, Severe mental retardation.			
PART II OTHER SIGNIFICANT FINDINGS See above			
20. DESCRIBE HOW INJURY OCCURRED Choked while being fed.			
21. TIME OF DEATH 12:15			
22. DATE SIGNED 6/1/67			
2. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inquest <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples			
EXAMINER'S NAME D.D. Caples, M.D.			
23. NAME OF CEMETERY OR REMATORY Mt Calvary Cemetery			
24. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave			
25. DATE OF DEATH 6/1/67			
26. DATE OF DEATH JUN 8 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07891

CERTIFICATE OF DEATH

07874

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		7 USUAL RESIDENCE (Where deceased lived if institution. Reside vs. before admission) b STATE Md. c COUNTY 1 d CITY OR TOWN 1	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		e LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1128 Baker Ave.		d STREET ADDRESS 1128 Baker Ave.	
3 NAME OF DECEASED Type or print) Ethel M. Sebasovich		4 DATE OF DEATH Month June Day 17 Year 1967	
SEX F	5 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 6, 1914
9 AGE at year last birthday 53 yrs		10 IF UNDER 1 YEAR Month 5 Days 17 Hours 17 Mins 17	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Late - Charles Bagant		14. MOTHER'S MARDEN NAME Thomas Fischbeck	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 216-03-4221	
17 INFORMANT Mr. Joseph Sebasovich 1128 Baker Ave. - 21207		18 ADDRESS 1128 Baker Ave. - 21207	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171 DUE TO cardiac arrest Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last involuntary cardiac arrest DUE TO heart (c) wall		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		20 THE DECEASED WAS UNDERLYING OR CHIEF CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER	
20a INJURY (Month Day Year) Hour 19 p.m.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury on Part II or Part I as near as possible)	
20c INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d PLACE OF INJURY (Home, Farm, Factory, street, office bldg., etc.)	
20e CITY OR TOWN Baltimore		20f STATE Md.	
2 certify that (1) this hospital attended the deceased from May 1 1967 to June 17 1967 that (2) we last saw the deceased alive on June 16 1967 and that death occurred at 1128 Baker Ave. from causes and on the date stated above			
22a SIGNATURE Andres E. Calas		22b DATE SIGNED 6/17/67	
23a PHYSICIAN'S NAME (Type)		23b ADDRESS 611 Frederick Rd.	
23c MEDICAL MOTION REMOVING BODY Burial		23d DATE THEREOF 6/19/67	
23e NAME OF CEMETERY OR REPOSITORY Lorraine Park Cem.		23f ADDRESS Baltimore, Md.	
24 FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a REC'D BY REGISTRAR JUN 20 1967	
25b REGISTRAR'S SIGNATURE William J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the registrars, page 2 of the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07892

CERTIFICATE OF DEATH

07875

1. PLACE OF DEATH a. COUNTY Baltimore		7. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland	
b. CITY OR TOWN Baltimore		b. COUNTY	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		d. STREET ADDRESS 3004 1/2 Niss Avenue, 21234	
2. NAME OF DECEASED First Middle Last CARMELA M. SPERRAZZA		4. DATE OF DEATH Month Day Year June 19 1967	
3. SEX Female		8. DATE OF BIRTH Month Day Year 4-11-99	
6. COLOR OR RACE White		9. AGE in years last birthday 68	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BIRTHPLACE (County & State or foreign country) Italy	
10a. Usual OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Angele DiRosa		14. MOTHER'S MAIDEN NAME Josephine DiRosa	
15. Was DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16. Social SECURITY NO 212-14-1395	
17. INFORMANT Husband- Frank J.		Address same	
18. CAUSE OF DEATH (List only one cause per line for 1a, 1b, and 1c) 1a. DEATH WAS CAUSED BY IMMEDIATE CAUSE to Carcinomatosis 1b. CONDITION, if any, which gave rise to immediate cause or stating the underlying cause Carcinoma of cervix 1c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART a) Hydronephrosis, Diabetes Mellitus, Atherosclerotic Heart Disease		INTERVAL BETWEEN UNSE AND OFATH	
20a. IDENTIFY WAS UNDER INJURY OR CONTRIBUTING CAUSE OF DEATH HILK 401 BY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part a if Part b is item 18)	
21a. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
21c. PLACE OF INJURY (Home, street, factory, street, office bldg, etc.)		21d. CITY or town County State	
21. I certify that this hospital attended the deceased from 6-15 to 6-19 and that death occurred at 3:55 PM from causes and on the date stated above		22. DATE WHEN 6/19/67	
23. SIGNATURE Juana S. Cockburn		24. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.	
25a. BIRTH INFORMATION Born 4-11-99		25b. DATE OF DEATH 6-23-67	
26. NAME OF CEMETERY OR CREMATORY Holy Redeemer		27. CITY or town County State Baltimore Maryland	
28. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Road		29. REC'D BY REGISTRAR J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove contents of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene.) Page 4 should be filed with the State Dept. of Health and Mental Hygiene.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

37893 21-76

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND

b. CITY OR TOWN Phoenix c. LENGTH OF STAY IN 26 3 weeks

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Phoenix Road

2. USUAL RESIDENCE (Where deceased lived 1 institution, residence before admission)
a. STATE Maryland b. COUNTY Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Phoenix

d. STREET ADDRESS Phoenix Rd

3. NAME OF DECEASED (Type or print) First Middle Last Ore Margaret Shaffer

4. DATE OF DEATH Month Day Year June 20 1967

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 12 June 1882 9. AGE IN YEARS IF UNDER 1 YEAR IF UNDER 24 HRS last birthday Months Days Hours Min 85 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Same

11. BIRTHPLACE (County & State, or foreign country) Abingdon Virginia 12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Alfred Rosen Plum 14. MOTHER'S MAIDEN NAME Johly St

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) NO 16. SOCIAL SECURITY NO. 212-24-5981 17. INFORMANT Daughter - Udonie Herman Address Westminster

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central Vascular accident
DUE TO (b) Cerebral & arterio-sclerotic vascular disease
DUE TO (c) 8 years

PART 2 OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) INTERVAL BETWEEN ONSET AND DEATH 1 day

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1 of item 18.)

20c. TIME OF INJURY Month, Day, Year 27 May 1967 20d. INJURY OCCURRED while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) at work 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 27 May 1967 to 20 June 1967, that (I) (we) last saw the deceased alive on 20 June 1967, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE Walter T. Kees 22b. DATE SIGNED 20 June 1967

22c. PHYSICIAN'S NAME (Type) WALTER T. KEES 22d. ADDRESS Cocheyville

23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 6/23/67 23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEM. 23d. LOCATION (City, town or county) State GREENMOUNT, MD.

24. FUNERAL DIRECTOR James G. Saffelt 25. ADDRESS 2515 E. MAIN ST 25b. REC'D BY REGISTRAR 22 June 1967 25c. REGISTRAR'S SIGNATURE Charles Judge



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 show it be filed with the State Dept. of Health or to burial cremation or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
07894
BALTIMORE MARYLAND
1967
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE
c. LENGTH OF STAY IN 1b 1011
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER
e. STREET ADDRESS 621 MURDOCK ROAD
f. RESIDENCE WHERE DECEASED LIVED, (Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED
First HETTY Middle ADELE Last SHEARMAN
4. DATE OF DEATH
Month JUNE Day 14 Year 1967
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH
Month 5 Day 5 Year 1924
9. AGE in years
Years 43 Months 7 Days 3
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REG NURSE
11. BIRTHPLACE (County and State or foreign country) BALTIMORE MARYLAND
12. CITIZENSHIP OF WHAT COUNTRY? USA
13. FATHER'S NAME MARION SHEARMAN
14. MOTHER'S MAIDEN NAME HETTY W. NOYES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes. (no. or unknown) No 16. SOC. SEC. NO. 218-26-6616
17. INFORMANT MR. H. BREMER SHEARMAN
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Lung CARCINOMA of Colon
b. DUE TO 2 years
c. DUE TO breast
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I a) 612 PARK AVE #4
b) INTERVAL BETWEEN ONSET AND DEATH
c) 2 years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

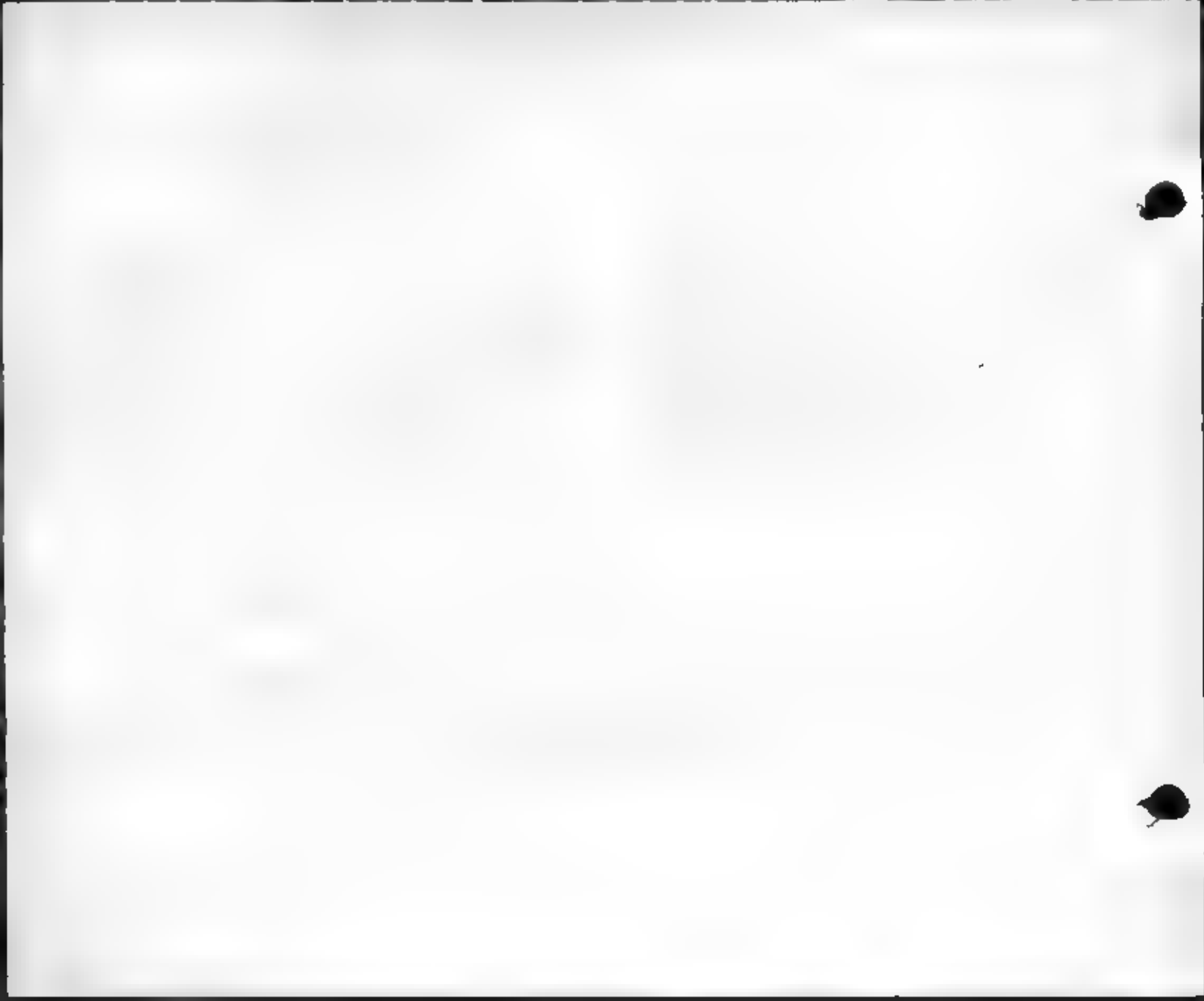
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? YES ☐ NO ☒
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. 5:31 p.m. 1967
20d. INJURY OCCURRED
Where ☐ at work ☐ Not at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 5:31, 1967, to 6:14, 1967, that (I, we) last saw the deceased alive on 6:14, 1967, and that death occurred at 6:14 P.M. from the causes and on the date stated above.
22a. SIGNATURE M. Usha Kumari M.D. ATTENDING PHYSICIAN ☐ MED. DIRECTOR ☐ STAFF PHYSICIAN ☒
22b. DATE SIGNED 6.14.67
22c. PHYSICIAN'S NAME (Type) M. USHA KUMARI
22d. ADDRESS 6701 N CHARLES STREET BALTIMORE MARYLAND
23a. BURIAL CREMATION REMOVAL (Specify) burial
23b. DATE THEREOF 6/17/1967
23c. NAME OF CEMETERY OR CREMATORY Wagner Chapel Cer.
23d. LOCATION (City, town or county) (State) Baltimore, Co. MD
24. FUNERAL DIRECTOR Mitchell-Wisniefeld Home-6500 York Rd. ADDRESS 21212
25a. RECD BY REGISTRAR Jun 16 1967
25b. REGISTRAR'S SIGNATURE Charles Judge



YN A 5ME
3500 4-40

1. MARTIN
2. DAVIS

DATE 11/28/1967 Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

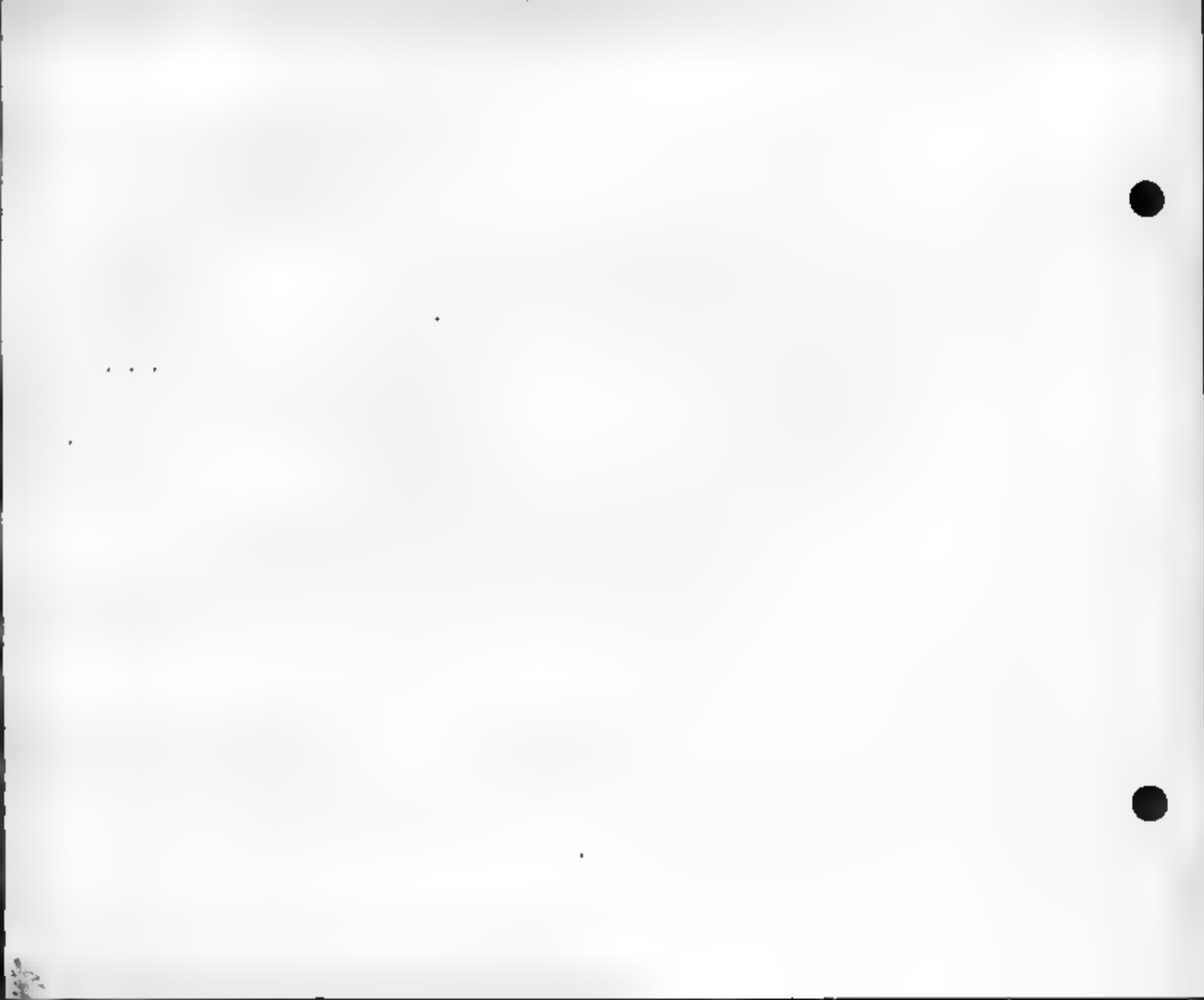
CERTIFICATE OF DEATH

07873

32896

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, filed in by the funeral director on page 3 show it he deeded for use as the basis for burial. Please remove carbon papers. Pages 2 and 3 should be filed with the State Dept of Health prior to burial. Burial should be completed within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN FORT HOWARD		2 USUAL RESIDENCE "Where deceased lived if institution. Residence before admission." a. STATE MARYLAND b. COUNTY BALTIMORE	
3 c. CITY OR TOWN FORT HOWARD d. NAME VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN BALTIMORE - 21223 f. STREET ADDRESS 41 S. STRICKER STREET	
4 NAME OF DECEASED First RICHARD Middle W. Last SHIPLEY		5 DATE OF DEATH Month JUNE Day 8 Year 1967	
6 SEX MALE	7 COLOR OR RACE WHITE	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 DATE OF BIRTH Month SEPT. Day 1 Year 1912
10 a. OCCUPATION Give kind of work done during most of working life, even if retired. MACHINE OPERATOR		b. KIND OF BUSINESS OR INDUSTRY PAINT SHOP	
11 c. BIRTHPLACE WEST VIRGINIA		d. STATE OF BIRTH U.S.A.	
12 e. FATHER'S NAME RUSSELL SHIPLEY		f. MOTHER'S MAIDEN NAME MAUDIE PHILLIPS	
13 a. WAS DECEASED EVER IN ARMED FORCES? YES		b. SOCIAL SECURITY NO. 217 10 1955	
14 c. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY BRONCHOPNEUMONIA		15 d. RECENT DEATH RECENT	
16 e. CONDITIONS IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. UNDETERMINED NEOPLASM WITH WIDESPREAD METASTASES		17 f. UNKNOWN	
18 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS. (List in Part 1.)			
19 a. IDENTIFY INJURY OR CAUSING DEATH IF PER NO. 1 NUCLEAR EXAMINER		20 b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, if known, or Part 1.)	
21 c. TIME OF INJURY Month Day Year Month 5 Day 31 Year 1967		22 d. INJURY IN WORK While <input type="checkbox"/> At work <input type="checkbox"/>	
23 e. PLACE OF INJURY Home <input type="checkbox"/> At work <input type="checkbox"/>		24 f. PLACE OF DEATH Home <input type="checkbox"/> At work <input type="checkbox"/>	
25 I certify that this hospital attended the deceased from 5/31/67 to 6/8/67 and that death occurred on 6/8/67 at 9:15 AM from cause and on the date stated above.			
26 SIGNATURE PETER V. JUVAN, M. D.		27 ATTENDING PHYSICIAN 6/8/67	
28 PHYSICIAN'S NAME PETER V. JUVAN, M. D.		29 ADDRESS VAH FORT HOWARD, MARYLAND	
30 BURIAL BALTIMORE NATIONAL		31 DATE OF BURIAL 6/12/67	
32 FUNERAL DIRECTOR WITZKE FUNERAL HOME		33 ADDRESS HOLLINS & GILMORE STS. BALTIMORE, MD.	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation, or removal and any other action with in 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07897

CERTIFICATE OF DEATH

17 50

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. STREET ADDRESS 4008 Chesmont Ave. # 6	
3 NAME OF DECEASED (Type or print) First Middle Last Howard D. Simmons		4 DATE OF DEATH Month Day Year June 22 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 10, 1901
9 AGE in years (last birthday) 66 yrs		10 IF UNDER 1 YEAR Months Days Hours Min. 66 yrs	
11 USUAL OCCUPATION (Give kind of work done during most or working life, even if retired) Retired Foreman		12 KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	
13 BIRTH PLACE (County & State or foreign country) North Carolina		14 CITIZEN OF WHA COUNTRY? U.S.A.	
15 FATHER'S NAME Lon Simmons		16 MOTHER MAIDEN NAME Mary ?	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give unit or dates of service) 212-05-7-63 A		18 SOCIAL SECURITY NO. Clara May Simmons, dght. above.	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO (b) Metastasis DUE TO (c) Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		NEURAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PAR		19 WA AUTOPSY PER ORDERED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. PHYSICAL IDENTIFICATION (Describe how INJURY OF INJURED (Nature of injury in Part III or list of item 8) OR CONTRIBUTING CAUSE OF DEATH FATHER NAME (Medical Examiner)		20b. DESCRIBE HOW INJURY OF INJURED (Nature of injury in Part III or list of item 8)	
20c. TIME OF INJURY BY Month Day Year Hour a.m. p.m. 9		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm factory, street, office bldg, etc.		20f. INJURY BY County State	
21 I certify that this hospital attended the deceased from May 19 9 67 to June 22, 19 67 that (I) (we) last saw the deceased alive on June 22 9 67 and that death occurred at 3:45 AM from causes and on the date stated above		22a. SIGNATURE <i>[Signature]</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) Pridipongse Vithespongse		22c. DATE SIGNED June 22, 1967	
22d. ADDRESS 7620 York Rd., Towson, 21204		22e. SIGNATURE <i>[Signature]</i>	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE WHEN OF 6/26/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Schumnek Funeral Home 3331 Brehms Lane #13		25. REGISTRATION BY REGISTRAR DATE JUN 26 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07820

07802

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b 8 Months			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2619 Edgemere Avenue				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere			
3. NAME OF DECEASED (Type or print) First Robert Middle F. Last Lee Jr.				4. DATE OF DEATH Month June Day 14 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/19/16	
9. AGE (in years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 45 Min.		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant in Hospital				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
13. FATHER'S NAME Robert F. Lee Sr.				14. MOTHER'S MAIDEN NAME Maggie Gregory			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 228-24-6767		17. INFORMANT (Sister) Address Mrs. Louise McCully 2619 Edgemere Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Pulmonary emphysema PART II. OTHERS ON F-CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 10, 1967 to June 14, 1967 , that (I) (we) last saw the deceased alive on June 13, 1967 , and that death occurred at 10:00 M. from the causes and on the date stated above.							
22a. SIGNATURE John V. Conway				22b. DATE SIGNED 6/15/67		22c. ADDRESS 911 "D" St. Sparrows Point, Md. 21219	
22d. PHYSICIAN'S NAME (Type) John V. Conway				22e. M. D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/17/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION (City, town or county) (State) Baltimore, Maryland				23e. LOCAL OR CITY, TOWN OR COUNTY			
24. FUNERAL DIRECTOR John J. Duda				24a. ADDRESS 7922 Wise Ave. Dandak, Md.		24b. REC'D BY REGISTRAR JUN 19 1967	
24c. REGISTRAR'S SIGNATURE Charles Judge				24d. REC'D BY REGISTRAR JUN 19 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please place in envelope with pages 1 and 2 and return to the State Dept. of Health prior to burial, cremation, or removal and interment within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

37893

7532

1. PLACE OF DEATH a. CITY BALTO b. COUNTY M.D.		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE BALTO b. COUNTY M.D.	
b. CITY OR TOWN (If outside corporate limits write P.R. and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN "b" 15 1/2 HRS	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO COUNTY GENERAL HOSP		d. STREET ADDRESS 4516 DRESDEN RD	
3. NAME OF DECEASED (Type in print) First ISRAEL Middle SINSKY Last		4. DATE OF DEATH Month 6 Day 9 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/99
9. AGE (In years last birthday) 68		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
11. OCCUPATION (Give kind of work done during most of working life even if retired) RETIRED		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (If county & State or foreign country) RUSSIA		14. TITLES OF WHA COUNTRY U. S	
15. FATHER'S NAME ISRAEL SINSKY		16. MOTHER'S MAIDEN NAME GARRISON	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		18. SOCIAL SECURITY NO	
19. INFORMANT ILLUDD A SINSKY - SAME AS ABOVE		20. ADDRESS	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION (b) 18 HRS (c) INTERVAL BETWEEN CAUSE AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN CAUSE AND DEATH (b) 18 HRS (c) INTERVAL BETWEEN CAUSE AND DEATH			
21a. APT. DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)	
22a. TIME OF INJURY Month Day Year Hour a.m. 9 pm 9		22b. NATURE OF INJURY (Home farm factory street office bldg. etc.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23a. I certify that (I) (this hospital) attended the deceased from 6/8/67 to 6/9/67 that (I) (we) last saw the deceased alive on 6/8/67 and that death occurred at 2:06 PM from causes and on the date stated above		23b. DATE SIGNED 6 9 67	
24a. SIGNATURE MORTON ELLIN		24b. ADDRESS BALTO COUNTY HOSP	
25a. PHYSICIAN'S NAME (Type) MORTON ELLIN		25b. ADDRESS BALTO COUNTY HOSP	
26a. BURIAL, CREMATION, REMOVAL, SPECIFY BALTO		26b. DATE THEREOF 6/11/67	
27a. NAME OF EMERY OR CREMATORY BALTO		27b. LOCATION (City or Town) (County) (State) BALTO MD	
28a. FUNERAL DIRECTOR Sylvan S Lewis & Son		28b. ADDRESS GARRISON	
29a. REC'D BY REGISTRAR JUN 12 1967		29b. REGISTRAR'S SIGNATURE Charles Judge	



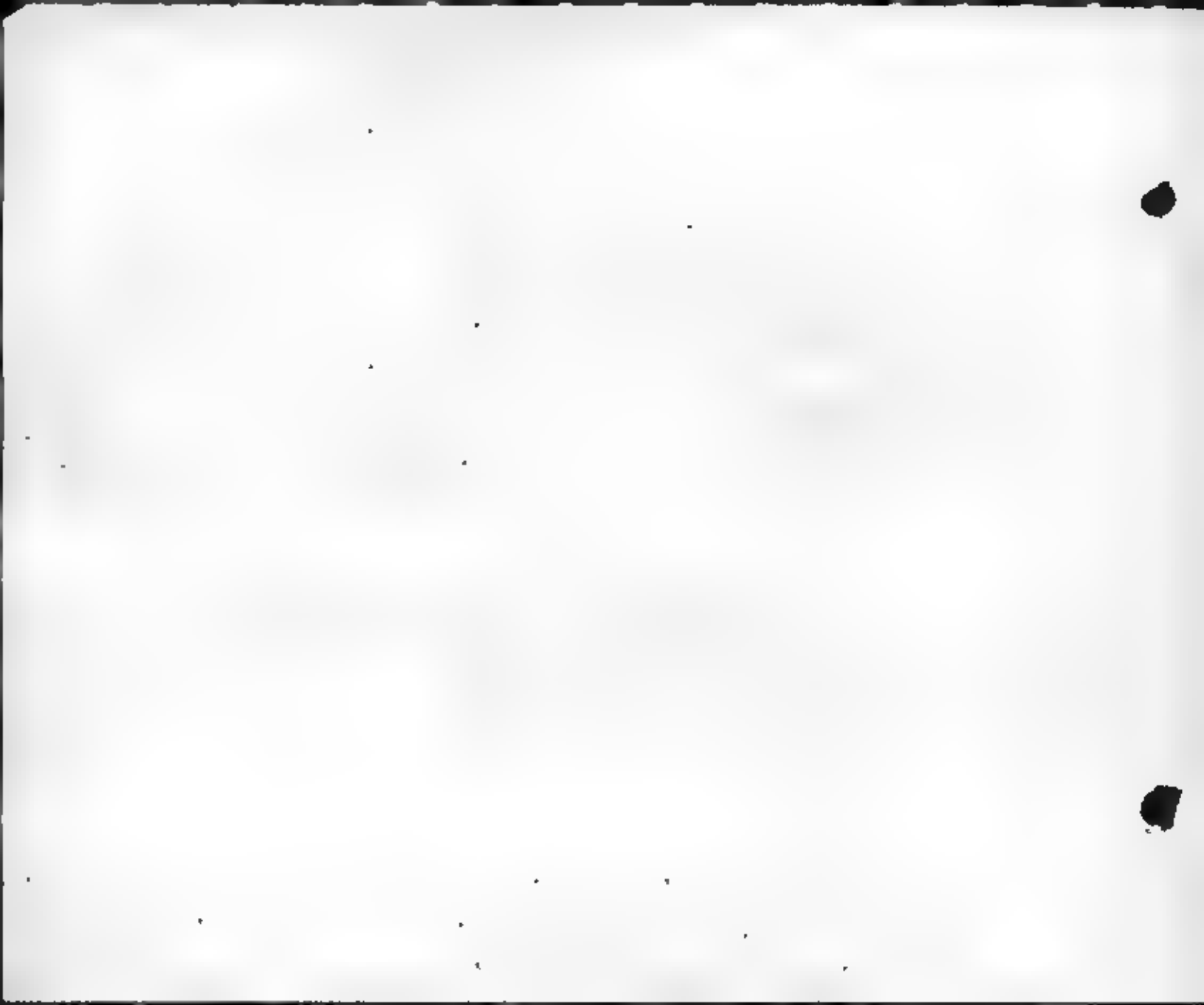
1. **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH & COUNTY Balto MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown 21133	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bz 353, Marriottsville Rd.		e. STREET ADDRESS Bz 353 Marriottsville Rd	
3. NAME OF DECEASED (Type or print) First John Middle T Last Skipper		4. DATE OF DEATH Month June Day 2 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1901
9. AGE (In years last birthday) 66 yrs.		10. FUNDING YEAR (FUND OF 74 HRS. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Roslyn, Md.		12. CITIZENSHIP OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Skipper		14. MOTHER'S MAIDEN NAME Millie Rhodes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217 01 5427	
17. INFORMANT Jane S. Wilson, 3702 Leburman Drive, 21133		Address Randallstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> </div> <div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> </div>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTORY NO. <input type="checkbox"/> CAUSE OF DEATH none			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. none			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY Home, farm, factory, street, office, etc. (State) _____			
21. certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 6-5-67	
EXAMINER'S NAME (Type) D. D. Caples, Md. Hanover Rd.		Address (Street, city, town or county) Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd; Randallstown, Md		25a. DECEASED BY REGISTRATION 1967 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
June 5, 1967 Wards Chapel Cem. ADDRESS 21133		DATE JUN 6 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

27301

67-04

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if in institution, list before admission) b. STATE Maryland c. COUNTY Baltimore	
b. CITY OR TOWN If on side of unincorporated limits, write RURAL and give nearest town Towson		c. LENGTH OF STAY IN b. 12 hours	
d. NAME OF HOSPITAL OR INSITUATION If not in hospital give street address: Greater Baltimore Medical Center		d. STREET ADDRESS: 8204 GrayHaven Road	
3 NAME OF DECEASED (Type in print) Lynraye (NMN) SKIPPER		4 DATE OF DEATH Month June Day 7 Year 1967	
5 SEX Female	6 COLOR OR RACE C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 6, 1967
9 AGE in year last birthday 12		10 IF UNDER 24 HRS. Month 12 Days 0	
On what OCCUPATION Give kind of work done during most of working life, even if retired		11 KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (County & State of foreign country)		13 COUNTRY OF BIRTH	
Baltimore County, Md.		USA	
14 FATHER'S NAME Glenn William Bullock		15 MOTHER'S MAIDEN NAME Tanie Raye Skipper	
16 DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service No		17 SOCIAL SECURITY NO. ---	
18 INFORMANT Dr. Pauline Lorvan, GBMC		Address ---	
19 CAUSE OF DEATH Enter only one cause plus line to (a), (b) and (c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 773.5 DUE TO Respiratory distress		20 TIME ELAPSED BETWEEN ONSET AND DEATH 12 hours	
CONDITIONS, if any, which gave rise to immediate cause, stating the underlying cause last. (b) Prematurity DUE TO (c) ---		21 TIME ELAPSED BETWEEN ONSET AND DEATH 12 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
22a. A. INJURY WAS NON-FATAL OR FATAL? B. DATE OF DEATH C. THE MEDICAL EXAMINER		23. DESCRIBE HOW INJURY OCCURRED (State nature of injury in Part I or Part II of item 8.)	
24. TIME OF INJURY Month Day Year Hour am pm 9		25. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
26. PLACE OF INJURY Home farm factory street office bldg. etc.		27. City or town County State	
28. I certify that (1) this hospital attended the deceased from June 6, 1967 to June 7, 1967 and that death occurred at 11:27 AM from causes and on the date stated above			
29. SIGNATURE R. Breitenacker M.D. ATTENDING PHYSICIAN		30. DATE SIGNED 6/7/67	
31. PHYSICIAN'S NAME (Type) BREITENECKER		32. ADDRESS ---	
33. BURIAL OR CREMATION (Specify) CREMATION		34. DATE OF BURIAL OR CREMATION 6/8/67	
35. NAME OF CEMETERY OR CREMATORY Greater Baltimore Med. Center - Towson		36. LOCATION City or town County State	
37. FUNERAL DIRECTOR R. Breitenacker, GBMC		38. RECEIVED BY REGISTRAR JUN 8/27 1967	
39. REGISTRAR'S SIGNATURE Charles Judge		40. DATE ---	

TO HOSPITAL, OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health in proper order for filing, cremation, or removal, and if any event, within 72 hours after death.



CERTIFICATE OF DEATH

07685



07902

1. NAME OF DECEASED

ALBERT D. SLESINGER

2. PLACE OF DEATH IN BALTIMORE, MARYLAND

3. FULL NAME OF
HOSPITAL OR
INSTITUTION

3 SUDBROOK COURT
BALTIMORE, MARYLAND

4. SEX

5. RACE

MALE WHITE

6. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED
MARRIED

7. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

8. FATHER'S NAME

LOUIS SLESINGER

9. Was Deceased Ever in U. S. Armed Forces?
Yes No or UNKNOWN III Yes Give year or dates of service

10. SOCIAL SECURITY NO

11. USUAL RESIDENCE A. on date of death B. on date of death C. on date of death

MARYLAND

12. CITY OR TOWN (If outside city hall, write R. R. or town ship)

BALTIMORE

13. STREET ADDRESS

3 SUDBROOK COURT

14. DATE OF BIRTH

4-7-81

15. AGE

86

16. BIRTHPLACE

17. CITIZEN OF WHAT COUNTRY

18. MOTHER'S MAIDEN NAME

BETTY MANDELBAUM

19. INFORMANT

20. ADDRESS

21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

This does not mean the mode of dying e.g. heart failure, asphyxia, etc. It means the disease or condition which caused death

22. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

23. CAUSE OF DEATH

24. DUE TO

25. INTERVAL BETWEEN ONSET AND DEATH

26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BY N. R. A. C. I. E.

27. I certify that (I) (the hospital) attended the deceased from that (I, (we) last saw the deceased alive on

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

28. SIGNATURE

29. PHYSICIAN'S NAME

ALAN BERNSTEIN

30. BURIAL CREMATION, DATE OF REMOVAL

31. NAME OF CEMETERY OR CREMATORY

32. LOCATION

819 PARK AVENUE, BALTIMORE, MARYLAND 21201

33. DATE SIGNED

6/19/67

JUN 20 1967

ANATOMY BOARD OF MARYLAND

34. NAME OF REGISTRAR

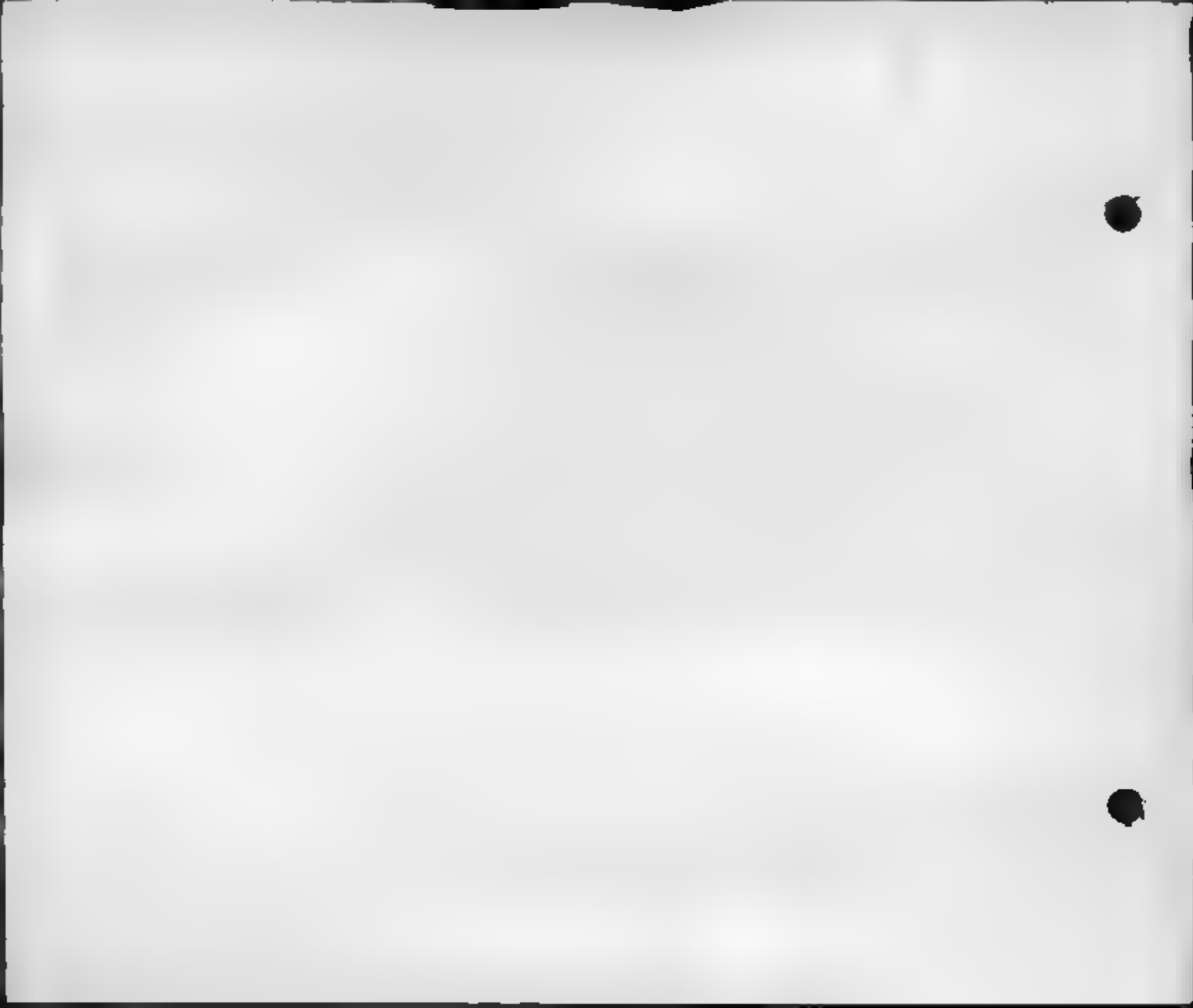
JOHNS HOPKINS MEDICAL SCHOOL

35. ADDRESS

JUN 22 1967

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician or FUNERAL DIRECTOR. A fee for this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial permit. Page 1 and 2 should be detached and use as the death certificate. Page 1 and 2 should be detached and use as the death certificate. Page 1 and 2 should be detached and use as the death certificate.





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial and if permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in agreement within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07904
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **BALTIMORE** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **TOWSON**
c. LENGTH OF STAY IN MD
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **GREATER BALTO. MED CENTER**

2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission)
a. STATE **MD**
b. COUNTY **1**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **ESSA**
d. STREET ADDRESS **46 CARROLLWOOD**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Baby SMITH - MALE INFANT.**
First Middle Last
4. DATE OF DEATH Month Day Year **6 24 1967**

5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **6. 22. 67**
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) Months Days **5 2**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) **Id.**
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **KENNETH EDWARD SMITH**
14. MOTHER'S MAIDEN NAME **MARJORIE LOU CROATO**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **PULMONARY HYALINE MEMBRANE DISEASE**
DUE TO **PREMATURITY.**
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO **MATERNAL DIABETES.** (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (d)

19. INTERVAL BETWEEN ONSET AND DEATH **48 HRS**

19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED while at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (1) (this hospital) attended the deceased from **6-22-1967** to **6-24-1967**, that (1) (we) last saw the deceased alive on **6-24-1967**, and that death occurred at **4 PM**, from the causes and on the date stated above.

22a. SIGNATURE **E. K. S. NARAYANAN** M.D. PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. PHYSICIAN'S NAME (Type) **E. K. S. NARAYANAN** 22c. ADDRESS **INTERN GREATER BALTO. MED. CTR.**
22d. DATE SIGNED **6. 24 67**

23a. BURIAL CREMATION REMOVAL (Specify) **C. 28/67** 23b. DATE THEREOF **6. 28/67** 23c. NAME OF CEMETERY OR CREMATORY **Boxia Math Cem** 23d. LOCATION (City town or county) (State) **Baltimore Md**

24. FUNERAL DIRECTOR ADDRESS **For 119 Community Center 300 N. Calver, 2** 25a. REC'D BY REG' STRAR **20 1967** 25b. REG' STRAR'S SIGNATURE **W. J. Jones**



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER

Every page of this report should be examined with 24 hours of death. If the report is not examined within 24 hours of death, the report should be forwarded to the Chief Medical Examiner's Office with the report.

TO FUNERAL DIRECTOR

Every page of this report should be used as a burial form. It should be used as a burial form and not as a removal form.

MARYLAND AND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET BALTIMORE MARYLAND 21201

07905

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07483

PLACE OF DEATH a. COUNTY Baltimore (Dundalk) 21222		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21222	
c. CITY OR TOWN Dundalk d. AGE 4 1/2 years		e. RESIDENCE Dundalk, Maryland 21222	
f. PLACE OF DEATH Eastcrest Swimming & Boating Club Pier		g. ADDRESS 1645 Gray Place	
h. NAME OF DECEASED North Boundary Road CALUP J. SMITH		i. DATE OF DEATH June 10- 1967	
j. SEX Male	k. RACE White	l. BIRTH DATE 8-6-58	m. BIRTH PLACE Maryland
n. OCCUPATION None	o. MARITAL STATUS None	p. COUNTRY OF BIRTH U.S.A.	q. COUNTRY OF DEATH U.S.A.
r. NAME OF INFORMANT George William Smith, Sr.		s. NAME OF INFORMANT Juanita Brewer	
t. ADDRESS OF INFORMANT NO		u. ADDRESS OF INFORMANT Juanita B. Smith 1645 Gray Place Balto., Md.	
v. CAUSE OF DEATH Drowning			
w. MANNER OF DEATH Fell into Bear Creek			
x. DATE OF DEATH 6-8-67			
y. PLACE OF DEATH Bear Creek			
z. I certify that the above information is true and correct to the best of my knowledge and belief.			
aa. ACTUAL SIGNATURE Melvin B. Davis		ab. DATE SIGNED June 12-67	
ac. EXAMINER'S NAME 6800 Mornington Road Balto., Md. 21222		ad. DATE OF EXAMINATION June 15 1967	
ae. BURIAL 6-14-67		af. PLACE OF BURIAL Baltimore National Cem. 5501 Fredk Ave. Balto., Md.	
ag. NAME OF BURIAL John J. Duda		ah. ADDRESS OF BURIAL 7922 Wise Avenue Balto., Md.	

VR A SWE 35
SM

21222



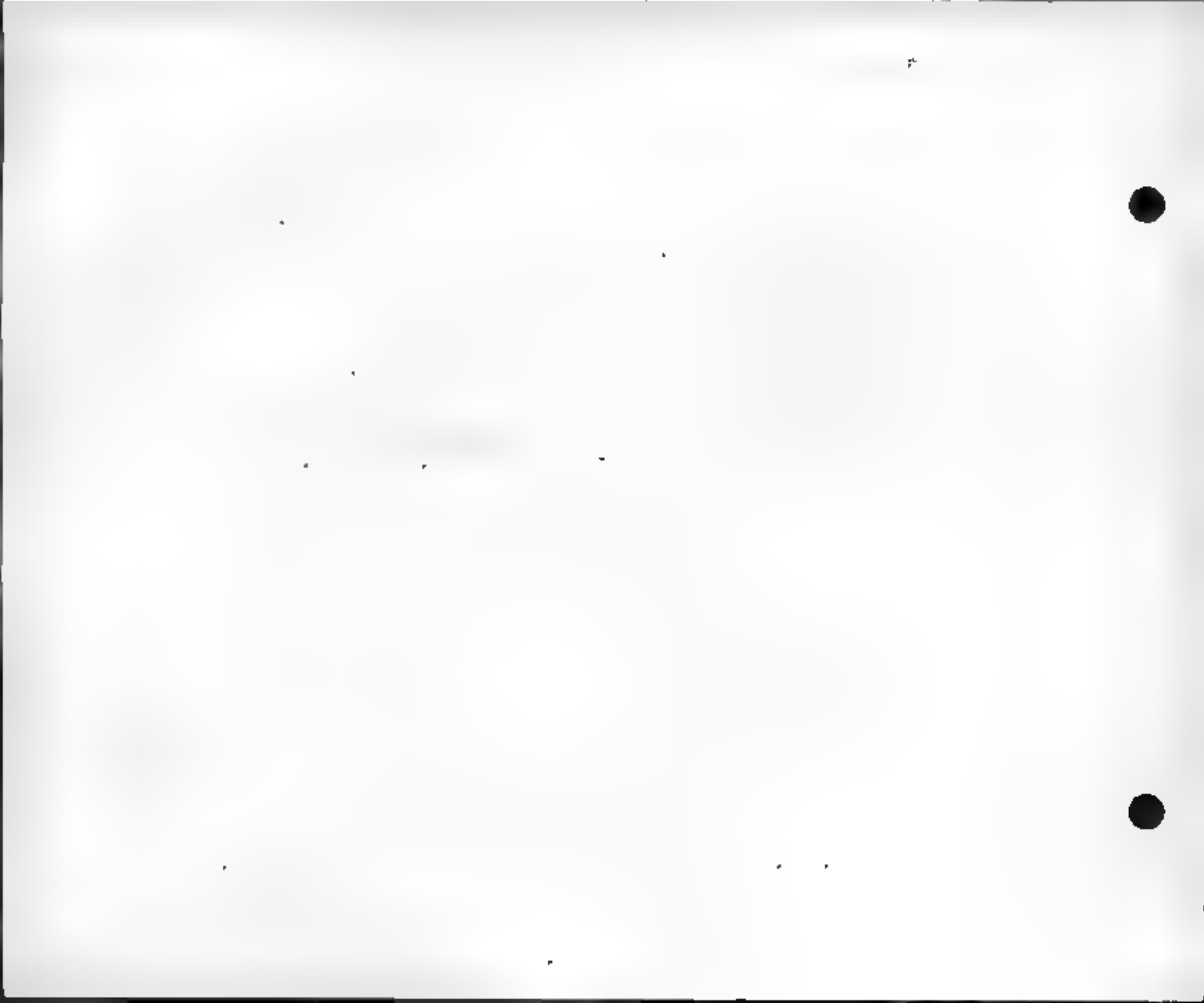
07906

CERTIFICATE OF DEATH

27553

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" MARYLAND		2 USUAL RESIDENCE "Where deceased lived if in care of Residence before adm. inst." a STATE Md. b COUNTY c CITY OR TOWN "If outside corporate limits write RURAL and give nearest town"	
3 NAME OF HOSPITAL OR INSTITUTION "If not in hospital give street address." Paradise Nursing Home		4 STREET ADDRESS 5556 Oakland Rd. b IF RESIDENT ON a CREW YF <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 NAME OF DECEASED First Catherine Middle M. Last Smith		6 DATE OF DEATH Month 6 Day 20 Year 1967	
7 SEX F.	8 COLOR OR RACE Cauc.	9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH 5/4/83
11 AGENT "If year last birthday" 84 yrs		12 AGE "If year last birthday" 84 yrs	
13 OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14 KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
15 BIRTHPLACE (County & State or foreign country) Baltimore, Md.		16 CITIZENSHIP OF WHAT COUNTRY? USA	
17 FATHER'S NAME Late Thomas J. Curran		18 MOTHER'S MAIDEN NAME Late Mary Henneley	
19 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		20 SOCIAL SECURITY NO. 217-48-03301	
21 INFORMANT Mr. Thomas J. Smith		22 ADDRESS 1226 W. Cross St.	
23 CAUSE OF DEATH "Late only one cause per line for a or b and PAR DEATH WAS CAUSED BY IMMEDIATE CAUSE: a Coronary Artery Disease with Angina Syndrome b Diabetes Mellitus c INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs		24 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I	
25 a IDENTIFYING INQUIRY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) b DESCRIBE HOW INQUIRY OR INJURY OCCURRED "Initial nature of injury in Part I or Part II of item B."		26 PLACE OF INJURY "Home, farm, factory, street, office, work, etc." 2/17/67	
27 TIME OF INQUIRY Month Day Year 6/19/67		28 INQUIRY "Home, farm, factory, street, office, work, etc." 2/17/67	
29 I certify that this hospital attended the deceased from 6/19/67 to 6/20/67 and that death occurred on 6/20/67 at 3:00 PM and that death was caused by Coronary Artery Disease with Angina Syndrome and Diabetes Mellitus		30 SIGNATURE W. E. McGrath, M. D.	
31 PHYSICIAN'S NAME Type W. E. McGrath, M. D.		32 ADDRESS 1303 Frederick Ave.	
33 BIRTH DATE 6/23/67	34 NAME OF MOTHER OR FATHER New Cathedral Cen.	35 COUNTY Baltimore, Md.	36 STATE Baltimore, Md.
37 FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		38 ADDRESS Witzke F. D. - 4101 Edmondson Ave.	
39 REGISTRATION JUN 21 1967		40 SIGNATURE W. E. McGrath, M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital at a pending physician TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial. A permit on or removal card may even with a death certificate.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7907

CERTIFICATE OF DEATH

1-1-67

1 PLACE OF DEATH
a. COUNTY

Baltimore

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

b. STATE Maryland c. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. ADDRESS (If not in hospital, give street address)

701 Gun Road

d. STREET ADDRESS

701 Gun Road

e. RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print)

Sister M. Isidore Smith

4 DATE OF DEATH Month Day Year June 10 1967

5 SEX

F Negro

7 MARRIED ☐ NEVER MARRIED ☒

8 DATE OF BIRTH

9 AGE (In years, last birthday) UNDER Year IF UNDER 24 MRS. Months Days Hours Min

January 10, 71 96 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

sewing

10b. KIND OF BUSINESS OR INDUSTRY

none

BIRTHPLACE (County & State, or foreign country)

Howard County, Md.

12 CITIZEN OF WHAT COUNTRY?

U.S.A.

13 FATHER'S NAME

Amos Smith

4 MOTHER MAIDEN NAME

Mary Braxton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service)

no

16. SOCIAL SECURITY NO

220-56-0133

17 INFORMANT

Sister M. Magdalen 701 Gun Road

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE IS

Pneumonia: Congestive Heart Failure 3 wks.

DUE TO

CONDITIONS (If any which gave rise to immediate cause & stating the underlying cause last)

DUE TO

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN NOAR a. IF WAY A TYPE Y PERFORMED YES ☐ NO ☐

20a. A. INCIDENT WAS INHERITABLE OR ON OCCASION OF DEATH IF INHERITABLE MEAN AS FARMING

20b. DESCRIBE HOW INJURY OCCURRED (Specify name of injury in Part II of form)

20c. TIME OF INJURY Month, Day, Year Hour, am, pm

20d. INJURY OCCURRED 20e. PLACE OF INJURY Home, farm, factory, street, office, bridge, etc. While at work ☐ Not while at work ☐

20f. City or town

21 I certify that this hospital attended the deceased from December 60 to 6/10 1967 and saw the deceased alive on 6/8 1967 and that death occurred at 4:30 M. from the causes and on the date named above.

22a. SIGNATURE

Emidio A. Franco

22b. ADDRESS

3350 Wilkens Avenue 21229

23a. BURIAL CREMATION DATE THEREOF

June 12/67

23b. NAME OF CEMETERY OR CREMATORY

New Catholic Cem. Balt. Md.

23c. LOCATION (City, town or county)

State

24. FUNERAL DIRECTOR SIGNATURE

Frank T. Chapman 11291 Maple St

ADDRESS

25a. REC'D BY REGISTRAR

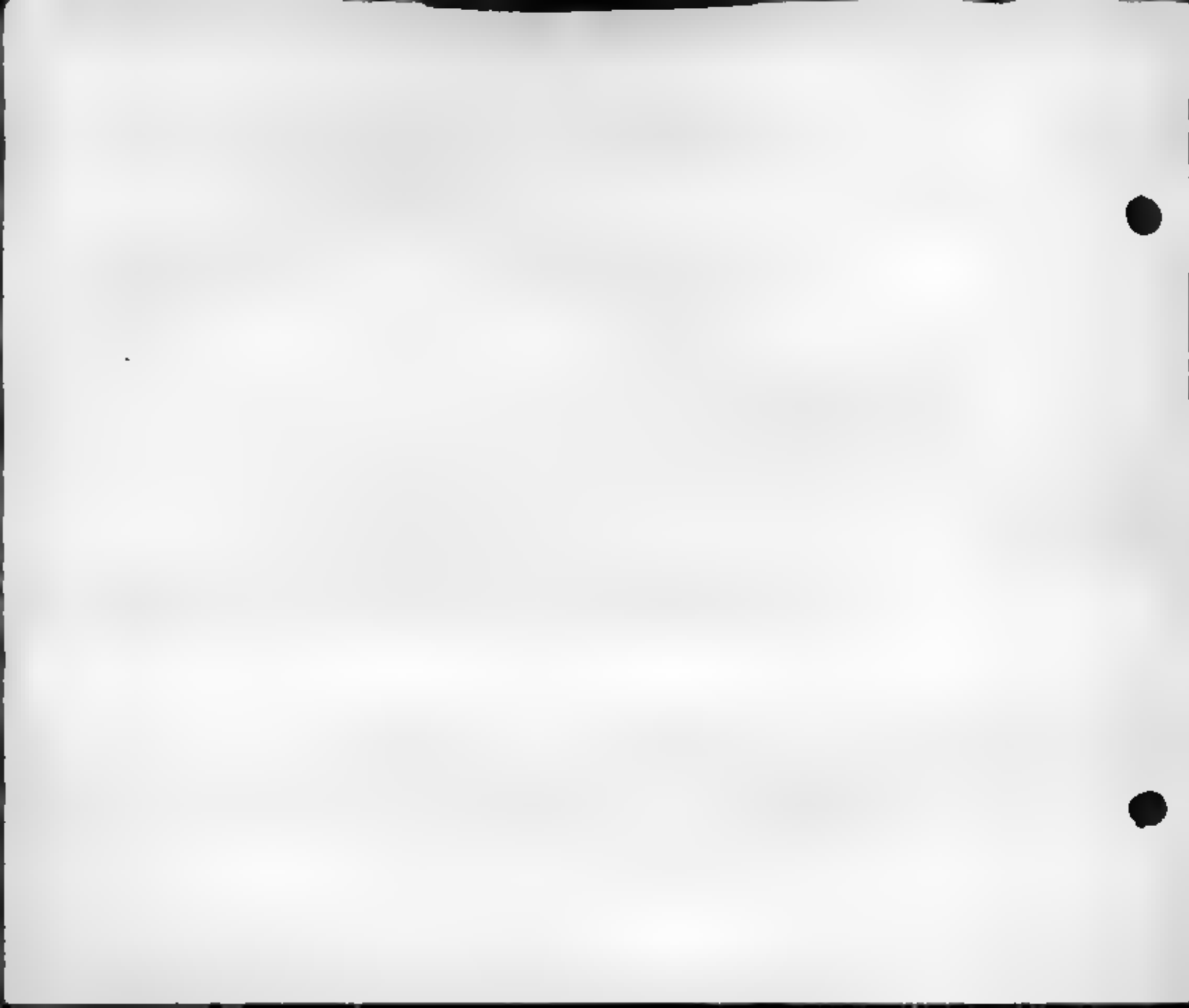
JUN 16 1967

25b. REGISTRAR'S SIGNATURE

Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay in being filed with the Health Department. The necessary photo and the preliminary written report are to be filed in items 8 & 9 of Pages 2 and 3 of this form. The final report is to be filed in item 10 of Page 4. The final report is to be filed along with form PM-1, Page 5, may be filed later. TO FUNERAL DIRECTOR: This certificate should be filed with the Health Department within 72 hours after death. Health prior to burial, cremation or entombment is not required.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07891

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN if outside corporate limits while RURAL and give nearest town Pikesville		2. USUAL RESIDENCE (Where decedent lived at last illness. Reside here before admission) a. STATE Virginia b. COUNTY Portsmouth	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital		4. STREET ADDRESS 302 DeKalb Avenue	
5. NAME OF DECEASED Type at birth Russell H. Smith		6. DATE OF DEATH Month June Day 5 Year 1967	
7. SEX Male	8. COLOR OR RACE White	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH 12/9, 1902
11. OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		12. KIND OF BUSINESS OR INDUSTRY Construction	
13. BIRTHPLACE (State or foreign) Alabama		14. COUNTRY OF BIRTH USA	
15. FATHER NAME Inoch Smith		16. MOTHER MAIDEN NAME Mary Frances	
17. Was decedent in ARMED FORCES? (If yes, give war and dates of service) No		18. Informant Cal Funeral Home, Chesapeake City, Va.	
19. CAUSE OF DEATH (If fatal, give cause and place of death and PART DEATH WA. ADULT BY IMMEDIATELY Arteriosclerotic Cardiovascular Disease Condition: If any which gave rise to the underlying cause Due to Due to			
20. PART II OTHER (ILLUSTRATION) CONDITIONS ON DEATH RECORD NO. RELATED TO DEATH No			
21. I certify that the above information is true and correct to the best of my knowledge and belief. 22. DATE SIGNED 6/6/67			
23. ACTUAL SIGNATURE Werner U. Spitz, M.D.		24. DEPUTY MEDICAL EXAMINER James L. Jones	
25. INITIAL DIRECTOR Renard		26. NAME OF FUNERAL HOME Sol Levinson & Bros. Inc.	
27. DATE OF DEATH 6/6/67		28. PLACE OF DEATH Portsmouth, Virginia	
29. DATE OF DEATH 6/6/67		30. DATE OF DEATH 6/6/67	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached to use as he by law-transit permit. Then please enclose carbon pages 1, 2, 3, 4, 5, and 6 should be filed with the State Dept of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07903

CERTIFICATE OF DEATH

07902

PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 12		c. LENGTH OF TAY IN b		7. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. TAI Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armacost Nursing Home				d. STREET ADDRESS 934 E. Lake Ave.		RESIDENCE ON 6. ARMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1. NAME OF DECEASED (Type in print) Cordelia England Sollers		2. DATE OF DEATH Month June Day 16 Year 67		3. DATE OF BIRTH 7/19/1887		4. AGE In years 79 Months 11 Days 27 Hours 11 Min 00	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		BIRTHPLACE (County & State or foreign country) Howard County		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. England				14. MOTHER'S MAIDEN NAME Camsadel Warfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-24-4504A		17. INFORMANT Basil D. Sollers, 934 E. Lake Ave.			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) None Noting the underlying cause (c) None DUE TO IMMEDIATE CAUSE (a) None DUE TO Conditions, if any, which gave rise to immediate cause (b) None Noting the underlying cause (c) None						18. I, the undersigned, certify that the above is a true and correct statement of the cause of death.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TOXIC PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DECEASED WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)		20c. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20d. (City or town) (County) (State)	
20e. TIME OF INJURY Month Day Year Hour a.m. 9 p.m. 9		20f. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20h. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from saw the deceased alive on 6/15/67 and that death occurred at 9:10 p.m. on 6/16/67 and on 6/16/67 at 9:10 p.m. and on 6/16/67 at 9:10 p.m.						22b. SIGNATURE Dr. Philip Whittlesey	
22a. PHYSICIAN'S NAME (Type)		22c. ADDRESS 600 W. Belvedere Ave.		22d. ADDRESS 600 W. Belvedere Ave.		22e. SIGNATURE Charles Jones	
23a. BURIAL REMAIN (If removal specify) Burial		23b. DATE THEREOF 6/19/1967		23c. NAME OF CEMETERY OR CREMATORY England		23d. LOCATION (City or town) (County) (State) Howard County Md.	
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co., 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR JUN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Jones		25c. REGISTRAR'S SIGNATURE Charles Jones	

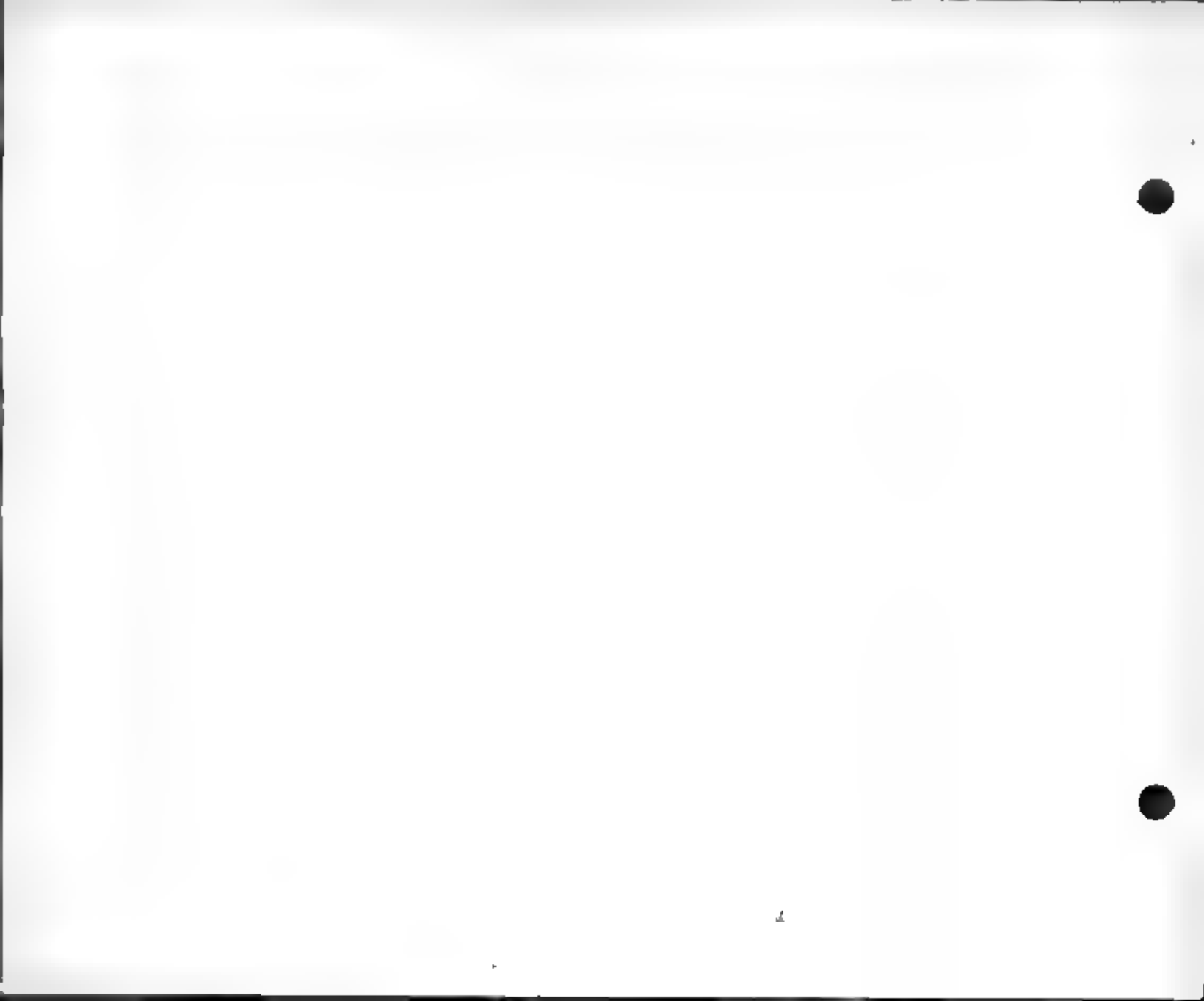


CERTIFICATE OF DEATH

2703

PLACE OF DEATH a COUNTY <u>Baltimore</u>		MARYLAND		2 USUAL RESIDENCE Where deceased lived if institution Residence before admission b STATE <u>Prmary and</u> c COUNTY <u>Baltimore</u>	
b CITY OR TOWN If outside the state omit state (RURAL) and give nearest town <u>Baltimore</u>		LENGTH OF STAY IN b <u>27 days</u>		c CITY OR TOWN If outside corporate limits, write RURAL and give nearest town <u>Baltimore Md</u>	
d NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address <u>Seignmore Co General Hospital</u>				e STREET ADDRESS <u>3032 Parkin Place</u>	
3 NAME OF DECEASED Type in print <u>Harry Shreeve Solomon</u>		First Middle Last <u>Harry Shreeve Solomon</u>		4 DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>M</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <u>12-11-1910</u>		9 AGE In years birthday <u>56</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
11a USUAL OCCUPATION Give kind of work done during most of working life (even if retired) <u>Animal attendant</u>		11b NAME OF BUSINESS OR INDUSTRY <u>Animal Hospital</u>		12 BIRTH PLACE (County & State or foreign country) <u>Baltimore Md</u>	
13 FATHER'S NAME <u>Charles S. Solomon</u>		14 MOTHER'S MAIDEN NAME <u>Ellen Beaver</u>		15 USUAL RESIDENCE <u>7926 Durh. H. Village Circle</u>	
16 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) a PARTIAL DEATH WAS CAUSED BY <u>1. Pneumonia</u> b IMMEDIATE CAUSE (a) <u>2. Sepsis</u> c DUE TO <u>3. Infection</u> d OTHER CAUSE (a) <u>4. Shock</u> e DUE TO <u>5. Infection</u> f OTHER CAUSE (a) <u>7. Sepsis</u>		17 INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>		18 INTERVAL BETWEEN ONSET AND DEATH <u>7 YEARS</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART II) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENTAL UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH IF FATHER NOT BY MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part II or Part II of item 8			
20c TIME OF INJURY Month Day Year Hour a.m. <u>9</u> p.m. <u>9</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY Home farm factory street office bldg etc	
20f (City or town) (County) (State)		20g (City or town) (County) (State)			
21 I certify that I, this hospital, attended the deceased from <u>5-29</u> to <u>6-24</u> , 19 <u>67</u> (that we) saw the deceased alive on <u>June 24, 1967</u> and that death occurred at <u>7 PM</u> from causes and on the date stated above					
22a SIGNATURE <u>Angelia B. Topalco</u>		22b DATE SIGNED <u>6-24-67</u>		22c PHYSICIAN'S NAME (print) <u>ANGELIA B. TOPALCO</u>	
22d ADDRESS <u>B-211</u>		22e ADDRESS <u>B-211</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE OF BURIAL, CREMATION, REMOVAL <u>June 30, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Green Ridge Cem</u>	
23d LOCATION (City or town) (County) (State) <u>Baltimore County Md</u>		23e LOCATION (City or town) (County) (State) <u>Baltimore County Md</u>			
24 FUNERAL DIRECTOR <u>Springfield</u>		24b ADDRESS <u>5739 Lehigh Rd. Landover Md 21115</u>		24c REGISTERED BY REGISTRAR <u>DATE JUN 27 1967</u>	
24d REGISTRAR'S SIGNATURE <u>John A. Judge</u>		24e REGISTRAR'S SIGNATURE <u>John A. Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to use as he buries the body. Then please remove carbon copies of pages 1 and 2 and send them with the State Department of Health. Death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07912

CERTIFICATE OF DEATH

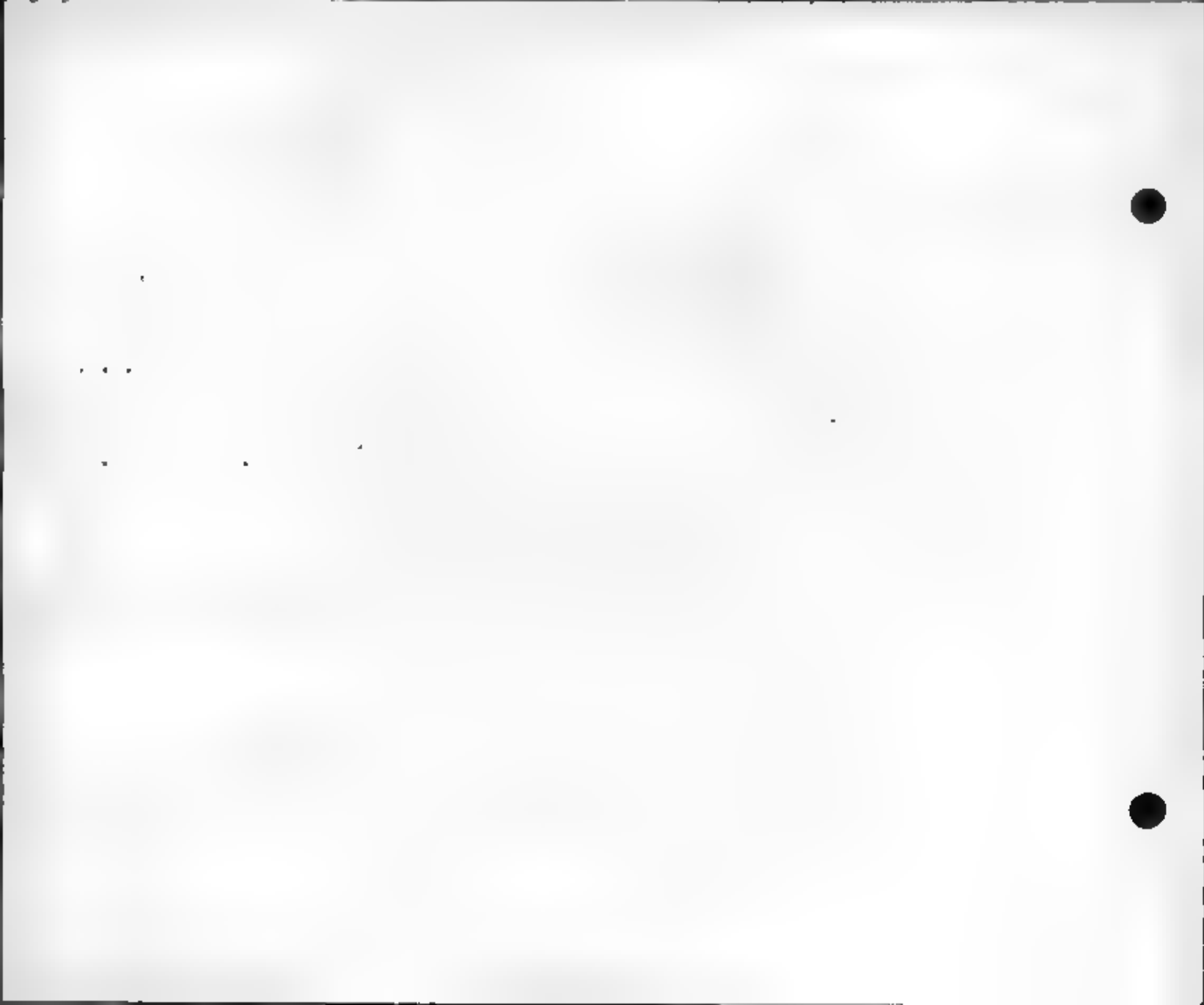
7525

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE Where deceased lived if institution Residence before admission a AT MARYLAND b COUNTY	
b CITY OR TOWN If include separate limits write RURAL and give nearest town PORT HOWARD		c OR TOWN If include separate limits write RURAL and give nearest town BALTIMORE	
d NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address VETERANS ADMINISTRATION HOSPITAL		e STREET ADDRESS 3301 FERNDALE AVENUE	
NAME OF DECEASED First Middle Last CHARLES PREVOST SPILMAN		4 DATE OF DEATH Month Day Year JUNE 30, 1967	
5 SEX MALE a COLOR OR RACE WHITE b MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> c WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 AGE OF BIRTH Month Day Year 7/7/00	
9 a OCCUPATION (Give kind of work done during most working life ever at present) CLERK b KIND OF BUSINESS OR INDUSTRY		10 a BIRTHPLACE If foreign state or territory BALTIMORE, MARYLAND b ZONE OF WAR U.S.A.	
13 FATHER'S NAME ROBERT L. SPILMAN		14 MOTHER'S MAIDEN NAME JULIE PREVOST	
15 a YES b NO c UNKNOWN d YES e NO f UNKNOWN g YES h NO i UNKNOWN Was he a veteran? (If yes give war or dates of service) YES WWII		16 a YES b NO c UNKNOWN Informant Warren A. Spilman-6100 Windsor Mill Rd. CLINICAL RECORD, VAH, FT. HOWARD, MD.	
17 a CAUSE OF DEATH (Fatal or non-fatal) b PERIOD OF ILLNESS (in weeks) PAC DEATH BY IMMEDIATE CAUSE PULMONARY INFARCTION		18 a b c WEEK	
19 a b c CONGESTIVE HEART FAILURE		20 a b c WEEKS	
21 a b c ARTERIOSCLEROSIS, SEVERE, GENERALIZED		22 a b c YEARS	
23 a b c NEPHROSCLEROSIS, CHRONIC		24 a b c PAR	
25 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		26 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
27 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		28 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
29 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		30 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
31 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		32 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
33 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		34 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
35 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		36 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
37 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		38 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
39 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		40 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
41 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		42 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
43 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		44 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
45 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		46 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
47 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		48 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
49 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		50 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
51 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		52 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
53 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		54 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
55 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		56 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
57 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		58 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
59 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		60 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
61 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		62 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
63 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		64 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
65 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		66 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
67 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		68 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
69 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		70 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
71 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		72 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
73 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		74 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
75 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		76 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
77 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		78 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
79 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		80 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
81 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		82 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
83 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		84 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
85 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		86 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
87 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		88 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
89 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		90 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
91 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		92 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
93 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		94 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
95 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		96 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
97 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		98 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	
99 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23		100 a b c OTHER SIGNIFICANT CONDITIONS ON PRESENT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND GIVEN IN PAR 23	

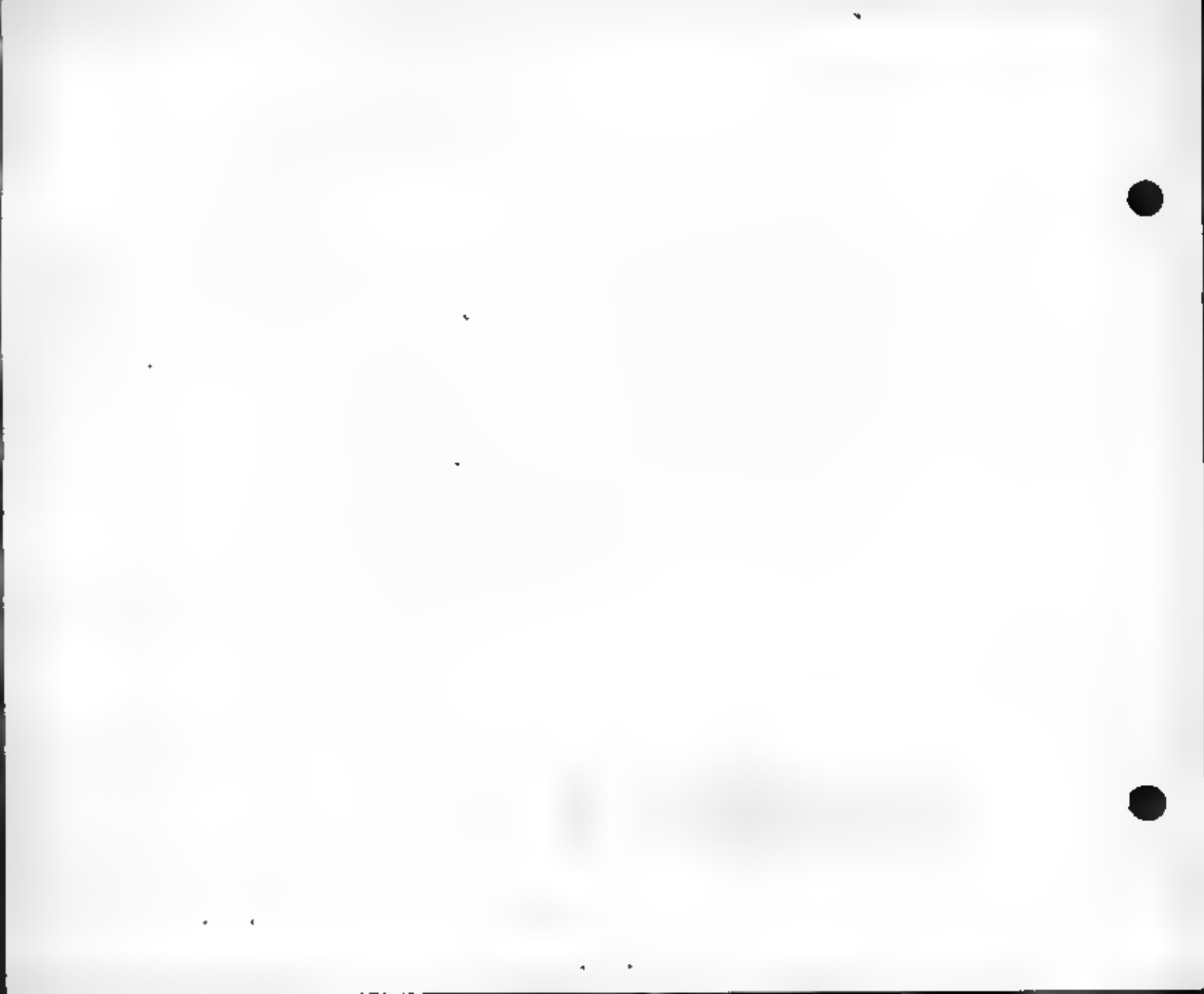
VAS 50
22

BURIAL
7-3-1967
Elmwood Amato

NEW CATHEDRAL CEMETERY
BALTIMORE, MARYLAND
ARMACOST FUNERAL HOME Chapel 3 1967
4600 LIBERTY HEIGHTS AVE. BALTIMORE, MD.
Charles Judge



WR A 5 41
25M 1 '62



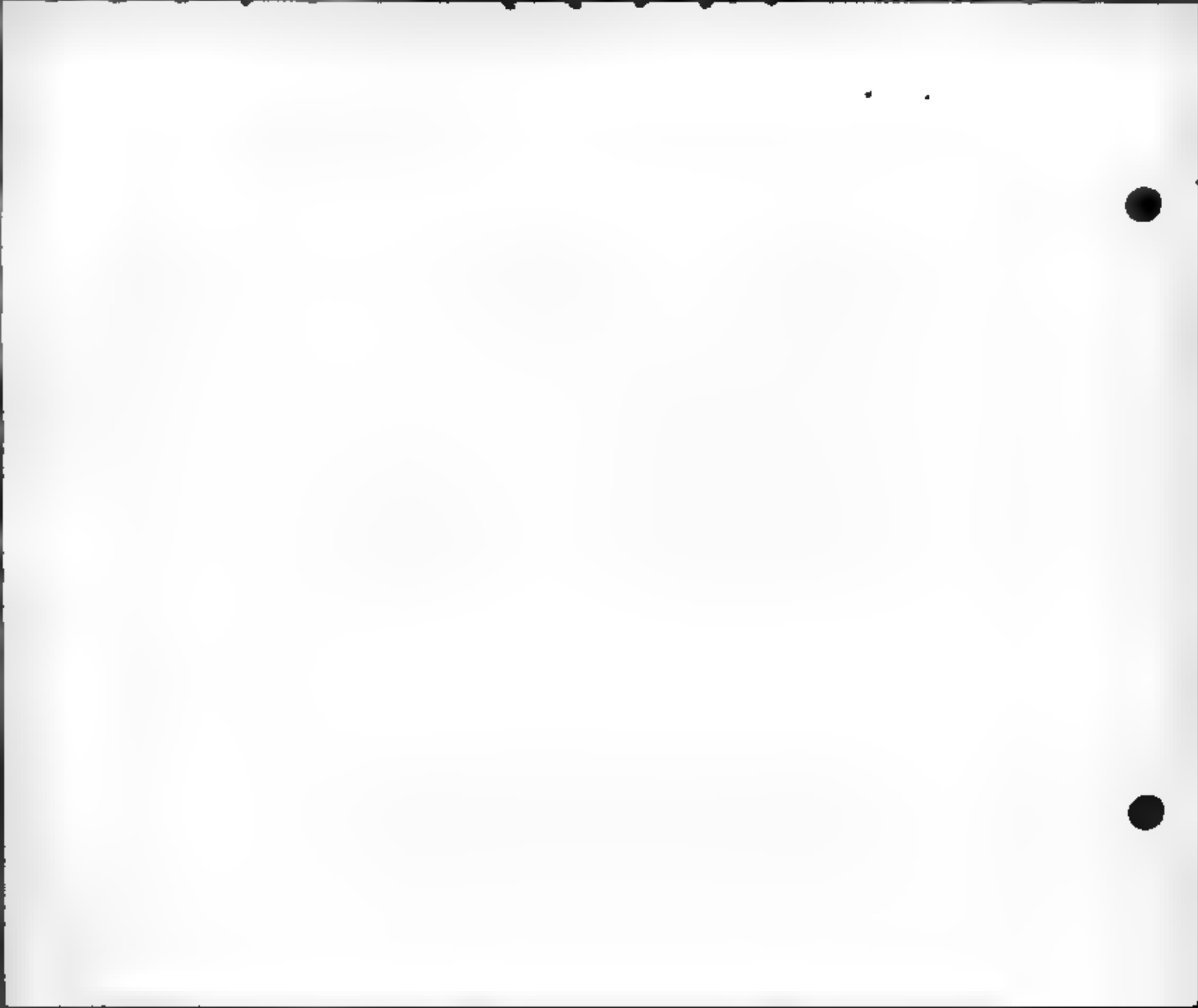
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 5-74
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND											
07914 CERTIFICATE OF DEATH 1356											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cathartsville</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>						e. STREET ADDRESS <u>Tullerton Baltimore County</u>					
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Ann</u> Last <u>Stanley</u>						4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 30, 1897</u> 9. AGE <u>77</u> years (last birthday) Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Samuel D. Stanley</u>						14. MOTHER'S MAIDEN NAME <u>Barbara M. Engelreil</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Records Spring Grove State Hospital</u> Address <u></u>											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I IMMEDIATE CAUSE a) <u>4320</u> DUE TO <u>Gravel, Int.</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>1</u> PART II OTHERS ON FICANT CONDITION CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TONG VEM N PART I a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING CAUSE OF DEATH <input checked="" type="checkbox"/> IF EITHER NOT BY MEDICAL EXAM NER											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u></u> 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>6-3-67</u> to <u>6-3-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-3-67</u> , and that death occurred at <u>2304</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Evelyn B</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u></u>											
22c. PHYSICIAN'S NAME (Type) <u>Evelyn B</u> 22d. ADDRESS <u></u>											
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6-6-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lawwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore</u>											
24. FUNERAL DIRECTOR <u>Lessahn F. Home</u> ADDRESS <u>7401 Belair Rd</u> 25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JUN 6 1967</u>											

MEDICAL CERTIFICATE ON



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7233

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Caronsville		2 USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY Baltimore	
3 NAME OF DECEASED First Jennie Middle M. Last Stemler		4 DATE OF DEATH Month 6 Day 21 Year 1967	
5 SEX Female COLOR OR RACE White		6 DATE OF BIRTH 12/22/83	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 AGE in years 83 Months 0 Days 0 Hours 0 Minutes 0	
9a. USUAL OCCUPATION Give kind of work done during most of working life (even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY None	
10. USUAL RESIDENCE (Give kind of work done during most of working life (even if retired)) Housewife		11. BIRTHPLACE (County & state of birth; country) Maryland	
12. FATHER'S NAME Frederick Dressel		13. MOTHER'S MAIDEN NAME Jennie Beckman	
14. SOCIAL SECURITY NO. None		15. INFORMANT Raymond H. Stemler Address 235 Edridge Way 21228	
16. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c) DEATH CAUSED BY IMMEDIATE CAUSE TO hypertension pneumonia Congestive heart failure A.S.C.V. disease		17. PERIOD OF ILLNESS (Enter number of days, weeks, months, or years) 3 days 1 month ?	
18. PAR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Enter nature of injury in Part I or Part II of death) Death by		19. WAS A DEATH OF PEACE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. INJURY OR DISEASE (Enter nature of injury in Part I or Part II of death) Death by		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of death) Death by	
21. TIME OF INJURY (Month, Day, Year) June 19 1967		22. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home	
23. I certify that (1) (this hospital) attended the deceased from June 19 1966 to June 21 1967 that saw the deceased alive on June 20 1967 and that death occurred at 9:55 AM from poison and on the date stated above		24. SIGNATURE OF PHYSICIAN Dr. D. C. McLaughlin	
25. PHYSICIAN NAME Type Dr. D. C. McLaughlin		26. ADDRESS 303 N. Rolling Rd.	
27. BURIAL REMOVAL Burial		28. DATE THEREOF 6/24/67	
29. NAME OF FINE (FIRE OR REMOVAL) Loudon Park Cemetery		30. LOCATION (City, town, county, state) Baltimore Md	
31. FUNERAL DIRECTOR Howard H. Hubbard F. H.		32. ADDRESS 4107 Wilkens Ave.	
33. DATE JUN 23 1967		34. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be delivered for use as the burial permit. Then please remove page 3 from the certificate and return it to the State Department of Health. Page 4 should be filed with the State Department of Health.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a bon paper's pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. Any event with a 72-hour delay after death.

(M)

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27916

57.00

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		7. USUAL RESIDENCE (Where deceased lived. + institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN If outside corporate limits write RURA and give nearest town <u>BALTIMORE</u>		c. CITY OR TOWN If outside corporate limits write RURA and give nearest town <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address <u>4509 MARYKNOLL ROAD</u>		d. STREET ADDRESS <u>4509 MARYKNOLL ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>HELVIA A. STERLING</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>67</u>	
a. SEX <u>MALE</u>	b. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 15, 1921</u>
9. At years last birthday <u>46</u>		10. UNDER 24 HRS. Month <u>June</u> Day <u>10</u> Hour <u>3</u> Minute <u>15</u>	
11. OCCUPATION (Give kind of work done during most of working life even if retired) <u>RCA</u>		12. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	
13. FATHER'S NAME <u>ROBERT J. STERLING</u>		14. MOTHER'S MAIDEN NAME <u>RAE GORDON</u>	
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <u>YES</u>		16. SOCIAL SECURITY NO. <u>334-14-8778</u>	
17. INFORMANT <u>MRS. LARY STERLING</u>		Address <u>4509 MARYKNOLL ROAD #8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PAR. 1. IMMEDIATE CAUSE (a) <u>Heart Disease</u> 4-20-67 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		19. INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <u>10 days</u>	
20. PAR. 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.		21. PAR. 3. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
22. PAR. 4. TIME OF INJURY Month, Day, Year Hour <u>10</u> AM PM		23. PAR. 5. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24. PAR. 6. PLACE OF INJURY Home, farm, factory, street, office, building, etc.		25. PAR. 7. CITY OR TOWN (County and State)	
26. PAR. 8. I certify that (this hospital) attended the deceased from <u>1952</u> to <u>6/10/67</u> that we last saw the deceased alive on <u>6/10/67</u> and that death occurred at <u>3 AM</u> from cause and at the date stated above.		27. PAR. 9. SIGNATURE <u>Edward S. Kallins</u> M.D.	
28. PAR. 10. PHYSICIAN'S NAME Type <u>DR. EDWARD S. KALLINS</u>		29. PAR. 11. ADDRESS <u>4300 LIBERTY LIGHTS AVENUE</u>	
30. PAR. 12. BURIAL, CREMATION, REMOVAL, SPECIFIC <u>SCRAP</u>		31. PAR. 13. DATE OF DEATH <u>6/11/67</u>	
32. PAR. 14. NAME OF FUNERAL HOME OR REMATORY <u>Hebrew Young Men</u>		33. PAR. 15. LOCATION (City or Town, County, State) <u>Baltimore, Md.</u>	
34. PAR. 16. FUNERAL DIRECTOR <u>SOL LEVINSKY</u>		35. PAR. 17. ADDRESS <u>6 BROS. INC., 4010 REIST. RD.</u>	
36. PAR. 18. DATE OF DEATH <u>JUN 14 1967</u>		37. PAR. 19. SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

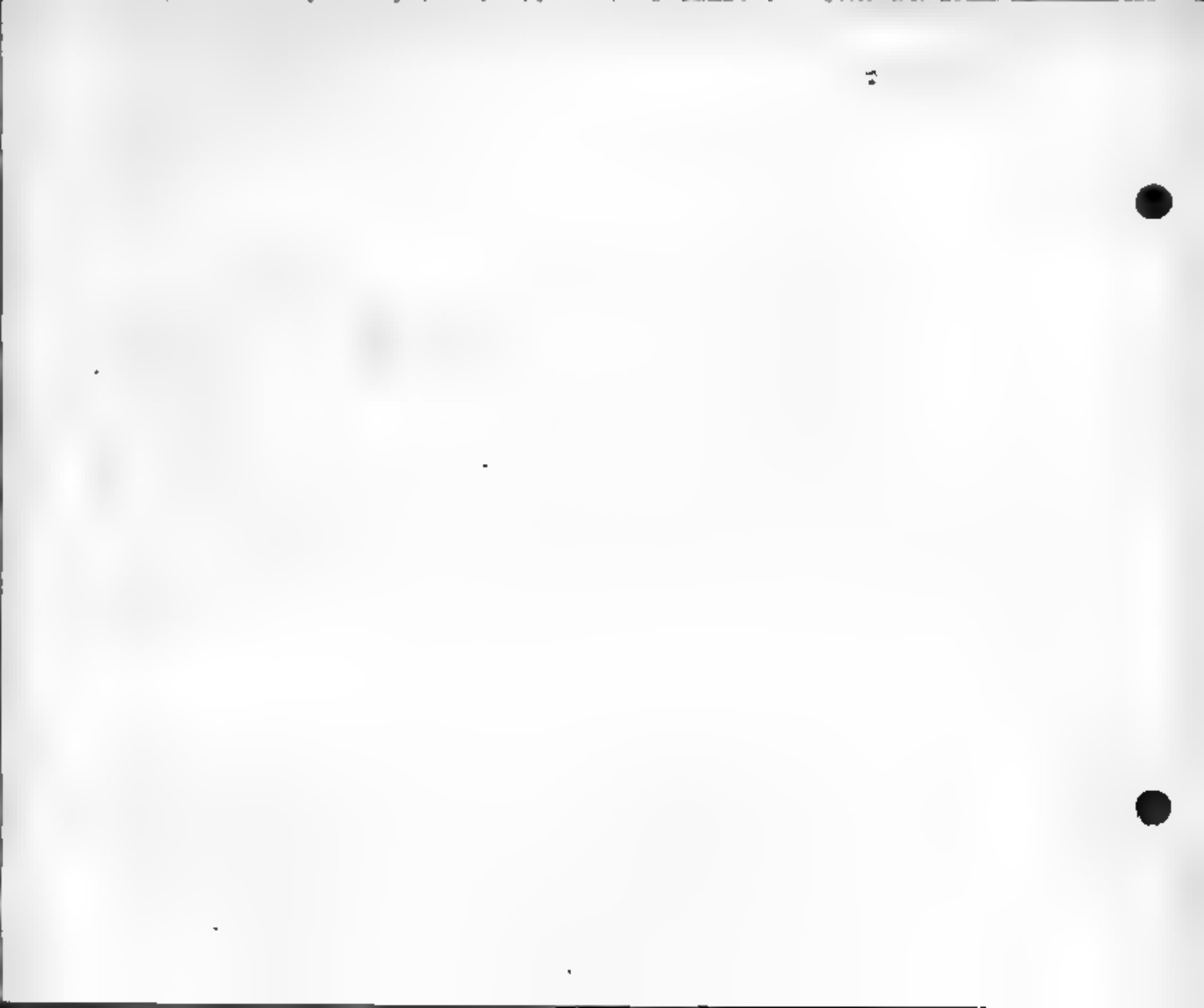
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

37917

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Baltimore c STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b CITY OR TOWN Baltimore	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		4 STREET ADDRESS 9206 Orbital Rd.	
5 NAME OF DECEASED First Middle Last Edwin D. Stevenson		6 DATE OF DEATH Month Day Year 6 1 1967	
7 SEX Male	8 COLOR OR RACE White	9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH 12/10 1905
11a OCCUPATION (Give kind of work done during 10 years of working life even if retired) Salesman		11b KIND OF BUSINESS OR INDUSTRY Furniture	11c BIRTHPLACE (County & State or foreign country) Maryland
12 FATHER'S NAME Edwin D. Stevenson		13 MOTHER'S MAIDEN NAME Emma	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		15 SOCIAL SECURITY NO 216-09-4063	16 INFORMANT Mrs. Sybil Stevenson Address Same
17 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions (b) which gave rise to immediate cause (a), stating the underlying cause (c) coronary arteriosclerosis and atherosclerosis.			INTERVAL BETWEEN INSTANT AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)			18 WERE ANY OTHERS PERMITTED TO VIEW BODY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING? OP CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18.)	
20c TIME OF INJURY Month Day Year Hour am pm	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that this hospital attended the deceased from 5/31 1967 to 6/1 1967 that we last saw the deceased alive on 6/1 1967 and that death occurred at 6:55 AM , from causes and on the date stated above			
22a SIGNATURE <i>Lawrence F. Misanik</i>		22b DATE SIGNED June 2, 1967	
22c PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR REMAOTORY	23d LOCATION (City or town) (County) (State)
Burial	6/5/67	Loudon Park Cem.	Balto., Md.
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.		25a REC'D BY REGISTRAR DATE JUN 5 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, the funeral director page 3 should be detached for use as the burial-transit permit. Please remove other pages. Pages 4 and 5 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director's page 3 should be detached for use as the burial transmittal permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to being cremation or interment and may affect the 72-hour safe death rule.

VR A75, 4
75M 102

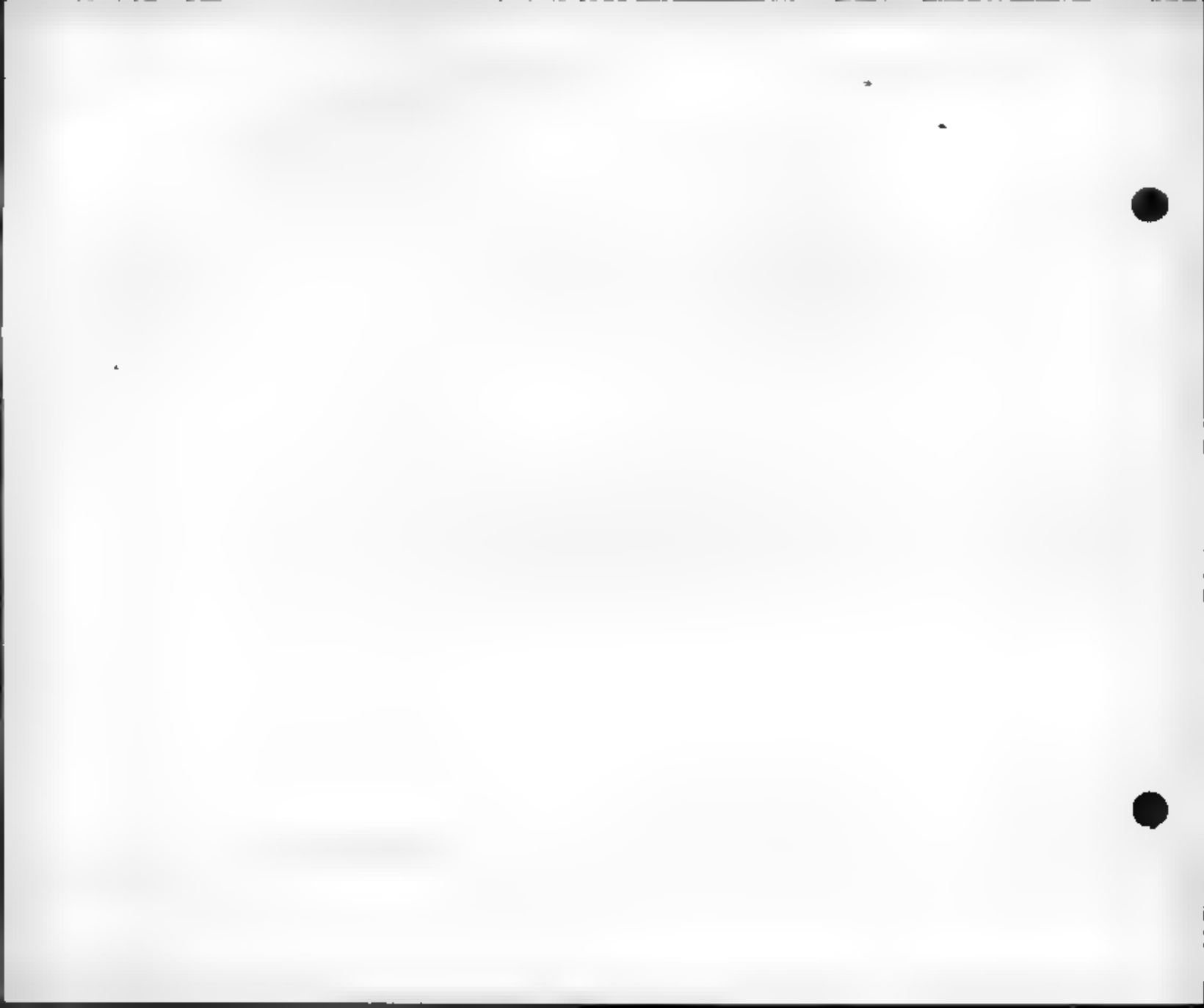
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

27918

CERTIFICATE OF DEATH

27901

1 PLACE OF DEATH a. COUNTY Baltimore		2 USCA. RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		b. COUNTY Baltimore	
c. LENGTH OF STAY IN IS 3yr6mth15dys		d. STREET ADDRESS 1011 West Mulberry Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IF RESIDENCE "ON A FARM" YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type in print) First Middle Last Eulalia H. Steward		4 DATE OF DEATH Month Day Year June 10 1967	
5 SEX female		6 COLOR OR RACE Negro	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH March 19, 1896	
9 AGE in years (month birthday) 71		10 UNDER 1 YEAR Months Days Hours Mins 71	
11a. US INDUSTRY/OCCUPATION (Give kind of work done during mps. c. working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY Var	
12 BIRTHPLACE (Country & state or foreign country) Var		13 REGION OF WHAT COUNTRY? U. S.	
14 FATHER'S NAME Unknown		15 MOTHER'S MAIDEN NAME Unknown	
16 WA. DET. AS GIVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		17 SOCIAL SECURITY NO 213-12-8798A	
18 INFORMANT Records: SPRING GROVE STATE HOSPITAL		19 ADDRESS Records: SPRING GROVE STATE HOSPITAL	
20 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right lobar pneumonia DUE TO causative force which gave rise to immediate cause (b) _____ noting the underlying cause (c) _____ last		21 INTERVAL BETWEEN ONSET AND DEATH 1 week	
22 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)		23 WA. A. DECEASED PERMITTED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. ACCIDENT WAS INDICATING IT OR INTERVIEWING NO. 24b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) IF EITHER NOTIFY MEDICAL EXAMINER		25a. DATE OF INJURY Month Day Year Nov. 21 1963	
25b. INJURY OF INJURY While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		25c. PLACE OF INJURY Home (enter to city street office bldg. etc.) Home	
25d. CITY OR TOWN Baltimore		25e. COUNTY Baltimore	
25f. STATE Maryland		25g. ZIP CODE 21228	
26 I certify that I (this hospital) attended the deceased from Nov. 21 1963 to June 10 1967 and saw the deceased alive on June 10 1967 and that death occurred at 7:00 AM from causes and on the date stated above		27 SIGNATURE Stella Wachslar, M.D.	
28 PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		29 DATE SIGNED 6-12-67	
30 SERIAL REPORT ON REMOVAL FORM 6/23/67		31 NAME OF PHYSICIAN OR NURSE Stella Wachslar, M.D.	
32 SIGNATURE Stella Wachslar, M.D.		33 DATE 6/22/67	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07913

CERTIFICATE OF DEATH

2002

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN FORT HOWARD		2 USUAL RESIDENCE Where deceased lived if institution a. STATE MARYLAND b. COUNTY _____	
c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town		c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 405 S. ANN STREET	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPH (J) STJES		4 DATE OF DEATH Month Day Year JUNE 26 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE OF BIRTH JUNE 13, 1895
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER		9b. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL	
10 BIRTHPLACE, county & state or foreign country POLAND		11 COUNTRY OF WHAT COUNTRY? U.S.A.	
12 FATHER'S NAME ANDREW STJES		13 MOTHER'S MAIDEN NAME MARY WUJEK	
14 Was he in U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service YES WW I		15 SOCIAL SECURITY NO 216 07 25 54	
16 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address _____	
17 CAUSE OF DEATH (Enter only one cause per line in a, b, and c) a. IMMEDIATE CAUSE SEPTICEMIA, CAUSE UNKNOWN b. INTERMEDIATE CAUSE UNKNOWN c. CONDITIONS, if any, which gave rise to immediate cause or relating the underlying cause 1534		18 INTERVAL BETWEEN DEATH AND EXAMINATION UNKNOWN	
19 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE COMPLICATION GIVEN IN PART 1 CEREBRAL THROMBOSIS DUE TO CEREBRAL ARTERIOSCLEROSIS			
20a. Was the death UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, BOTH MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 of item 18)	
21. TIME OF INJURY Month Day Year Hour a.m. p.m. _____	22. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	23. NATURE OF INJURY Home farm factory, street, office bldg., etc. _____	24. CITY or town county state _____
25. I certify that (this hospital attended the deceased from 6/25/67 to 6/26/67 and that death occurred at 3:30AM from causes and on the date listed above)			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 6/26/67	
22c. PHYSICIAN'S NAME Type JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL RITE BURIAL	23b. DATE OF BURIAL 6/27/67	23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	23d. LOCATION City or town county state DUNDALK, MARYLAND
24. FUNERAL DIRECTOR WEBER FUNERAL HOME		25a. REG'D BY REGISTRAR DATE 11-28-1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use of the burial-transit permit. This please remove carbon pages 3 and 4 and should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event within 72 hours after death.



page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please re-ave carbon papers, page 1 and 2, and place them in the envelope with the certificate. The certificate should be filed with the State Dept. at least 48 hours prior to burial cremation or removal and in any case within 72 hours after death.

PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		7. USUAL RESIDENCE (If home deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not hospital, give street address) <u>Baltimore County General Hosp</u>		e. STREET ADDRESS <u>8142 Scotts Level Rd.</u>	
f. NAME OF DECEASED First <u>Anne</u> Middle <u>ILENE</u> Last <u>Surdin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>	
SEX <u>F</u>	5. COLOR OR RACE <u>W</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/50</u>
9. AGE in years (last birthday) <u>16</u>		10. UNDER 1 YEAR Months <u>16</u> Days <u>16</u>	
11. INDUSTRY OR OCCUPATION (Give kind of work done during most of working life even if retired) <u>STUDENT</u>		12. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
13. BIRTHPLACE, Country & State or foreign country <u>Baltimore, Maryland</u>		14. COUNTRY OF BIRTH <u>USA</u>	
15. OTHER NAME <u>Harry Surdin</u>		16. MOTHER'S MAIDEN NAME <u>Gold Berg, E. A.</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>NO</u>	
19. INFORMANT <u>Hospital Records</u>		Address	
20. CAUSE OF DEATH (Enter only one cause per line fns (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatitis of liver with metastases</u> DUE TO Conditions if any which gave rise to immediate cause (a) stating the underlying cause last (b) <u>4 months</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
21a. AGE DEPT WAS UNDER 1 YR <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of item 8.)	
22a. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>9</u>	22b. INJURY OR URFED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	22c. PLACE OF INJURY Home farm factory street office bldg. etc	22d. (City or town) County (State)
23. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> to <u>June 30</u> , 1967 that I saw the deceased alive on <u>6/30</u> , 1967 and that death occurred at <u>7A</u> M from causes and on the date stated above			
24. SIGNATURE <u>Bernard Burgin</u>		25. DATESIGNED <u>6/30/67</u>	
26. PHYSICIAN'S NAME (Type)		27. ADDRESS <u>6724 Linton Rd. Suite 15, Pa</u>	
28a. BURIAL CREMATION REMOVAL (Specify)	28b. DATE THEREOF <u>7/2/67</u>	28c. NAME OF CEMETERY OR CREMATORY <u>C. ILL. A. L. O. (Arlington)</u>	28d. LOCATION (city or town) County (State) <u>BALTIMORE, MD, LA</u>
29. FUNERAL DIRECTOR <u>S. L. L. L. & SONS, Inc.</u>		30. RECEIVED BY REGISTRAR <u>DATE JUL 5 1967</u>	
31. REGISTRAR'S SIGNATURE		32. REGISTRAR'S SIGNATURE	



ATLANTIC STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07921

CERTIFICATE OF DEATH

(750)

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived 1 month before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b IF OR "OWN" outside corporate limits write RURAL and give nearest town <u>Crofton</u>		1c OR "OWN" outside corporate limits write RURAL and give nearest town <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Baltimore County General</u>		d STREET ADDRESS <u>3737 Croft Lane</u>	
3 NAME OF DECEASED Type or print <u>Ida (SUGARMAN) Green</u>		4 DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 RACE OR RAI <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE at birth <u>86</u> yrs
9 AGE at death yrs <u>86</u>		10 IF UNDER 1 YEAR Mo. <u>6</u> Days <u>7</u>	
11a KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11b BIRTHPLACE (Country & State or foreign country) <u>USA</u>	
12 FATHER'S NAME <u>Belkin Louis</u>		13 MOTHER'S MAIDEN NAME <u>Leven Leah</u>	
14 WA. OF ASST FIVE IN U.S. ARMED FORCES (Yes, no or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		15 SOCIAL SECURITY NO <u>UNKNOWN</u>	
16 INFORMANT <u>MR. GEORGE SUGARMAN</u>		Address <u>3204 FALLSTAFF ROAD</u>	
8. CAUSE OF DEATH (List only one cause per line for a, b and c) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4281 DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b) <u>Arteriosclerotic vascular heart disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS INDUCING IT OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 8) <input type="checkbox"/>	
20c TIME OF INJURY Month Day Year Hour am p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY Home farm, factory, street, office bldg. etc.	20f (City or town) (County) (State)
21 I certify that (1) this hospital attended the deceased from <u>5/30</u> 19 <u>67</u> to <u>6/7/67</u> 19 <u>67</u> that (2) we last saw the deceased alive on <u>6/7</u> <u>9</u> <u>47</u> and that death occurred at <u>5</u> <u>30</u> P.M. from causes and on the date stated above			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>6/7-67</u>	
22c PHYSICIAN'S NAME Type: <u>[Signature]</u>		22d ADDRESS <u>BALTIMORE COUNTY CLINICAL HOSPITAL</u>	
23a BURIAL, CREMATION, REMOVAL, SPECIAL	23b DATE THEREOF <u>6/8/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>LUBA ITZ MUSACH ART</u>	23d LOCATION (City or town) (County) (State) <u>BALTIMORE MARYLAND</u>
24 FUNERAL DIRECTOR <u>SOL LEVITSKY & BROS. INC., 6010 REIST., PD.</u>		25a RECEIVED BY REGISTRAR DATE <u>JUN 12 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and page 4 should be filed with the State Dept of Health.



07922

CERTIFICATE OF DEATH

07905

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Catonsville c. NAME OF HOSPITAL OR INSTITUTION 720 Maiden Choice Lane # 21228.		2 USUAL RESIDENCE (When deceased lived in institution, Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN Catonsville d. STREET ADDRESS 720 Maiden Choice Lane #28		e. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED Type of print Sr. Mary Margaret of the Sacred Heart, O.P. SEX Female COLOR OR RACE White MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 14a. PLACE OF BIRTH Nun 14b. KIND OF BUSINESS OR INDUSTRY Catholic		4 DATE OF DEATH Month June Day 29 Year 1967 5 DATE OF BIRTH Month 84 Day 22 Year 1883 6 BIRTHPLACE (City & State or foreign country) Paterson, N.J. 7 IT IS THE WILL OF WHAT COUNTRY? U.S.A.		8 MOTHER'S MAIDEN NAME Sarah Marie Brown	
13. FATHER'S NAME Henry Amos Taylor		9 MOTHER'S MAIDEN NAME Sarah Marie Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 219-54-3752J		17. INFORMANT Address: Mother Mary of the Divine Heart. Same.	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO CONDITIONS, if any, which gave rise to immediate cause (b) STATE THE UNDERLYING CAUSE (c) 1. HEART DISEASE 2. MYOCARDIAL INFARCTION 3. HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH			
PART II: OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACQUIDENT WAS UNDER TRAINING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 8.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. CITY or town		20g. COUNTY		20h. STATE	
21. I certify that (1) (the hospital) attended the deceased from 7/1/67 to 7/29/67 that saw the deceased give an. 8:30 a.m. and that death occurred at 10:00 a.m. on the date stated above					
22a. SIGNATURE John H. Shaw		22b. ADDRESS 5800 Edmondson Ave. Balto., 28, Md.		22c. DATE SIGNED July 29, 1967	
23a. BURIAL, CREMATION, REMOVAL, OR OTHER BURIAL		23b. DATE THEREOF 7-3-67		23c. NAME OF CEMETERY OR CREMATORY Convent Cemetery	
23d. LOCATION (City or Town) Baltimore		23e. COUNTY MD.		23f. STATE MD.	
24. FUNERAL DIRECTOR Charles J. Feiler		24a. ADDRESS 901 S. Conkling St. Baltimore, 21224, Md.		25. REC'D BY REGISTRAR Charles Judge	
25a. DATE JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, pages 1 and 2, and place them in the envelope provided. This envelope, with pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VR 3 4
25M 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07923

07906

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Towson</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Joseph Hospital</u>		e STREET ADDRESS <u>1103 N. Ainsworth St.</u>	
3 NAME OF DECEASED Type or print <u>willie</u> M. <u>Taylor</u>		4 DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/18/43</u>
9 AGE (In years last birthday) <u>23</u> yrs		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min <u>12</u>	
11a USUAL OCCUPATION (Give kind of work done during mos. of working life even if retired) <u>Yellow Cab Co.</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Taxicab Co.</u>	
12 BIRTHPLACE (County & state or foreign country) <u>North Carolina</u>		13 IF IN WHAT COUNTRY?	
14 FATHER'S NAME <u>Willie B. Taylor</u>		15 MOTHER'S MAIDEN NAME <u>Sadie</u>	
16 Was deceased ever in U.S. Armed Forces? (Yes, no or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO.	
18 Informant's name <u>Sadie Taylor</u>		19 Address <u>1103 N. Ainsworth St.</u>	
20 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY <u>731X</u> IMMEDIATE CAUSE (a) <u>Massive intracerebral hemorrhage</u> DUE TO b <u>Acute leukemia</u> DUE TO c <u>Acute leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Acute leukemia</u>		21 Was an autopsy performed? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a ACT OF DEATH (Enter nature of injury in Part II of item B) OR CONTRIBUTING CAUSE OF DEATH (If other notify medical examiner)		23 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item B)	
24 TIME OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u> Hour <u>am</u> <u>pm</u>		25 PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at work</u> <input type="checkbox"/> <u>at home</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>	
26 I certify that (1) this hospital attended the deceased from <u>June 28, 1967</u> to <u>June 30, 1967</u> and that death occurred at <u>6:55 PM</u> from causes and on the date stated above		27 SIGNATURE <u>Reynaldo Orjuela-Gomez, M.D.</u>	
28 PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela-Gomez, M.D.</u>		29 ADDRESS <u>7600 York Rd., Towson, Md. 21204</u>	
30 BURIAL REMOVAL REMOVAL SPECIFY <u>to normal</u>		31 DATE THEREOF <u>July 3/67</u>	
32 NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		33 LOCATION (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
34 FUNERAL DIRECTOR <u>Wm. T. & L. Brown</u>		35 ADDRESS <u>1129 N. Calver St.</u>	
36 RECD BY REGISTRAR <u>JL</u>		37 REGISTRAR'S SIGNATURE <u>1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and any event within 72 hours after death.

VS 155 (4)
25M 1/67

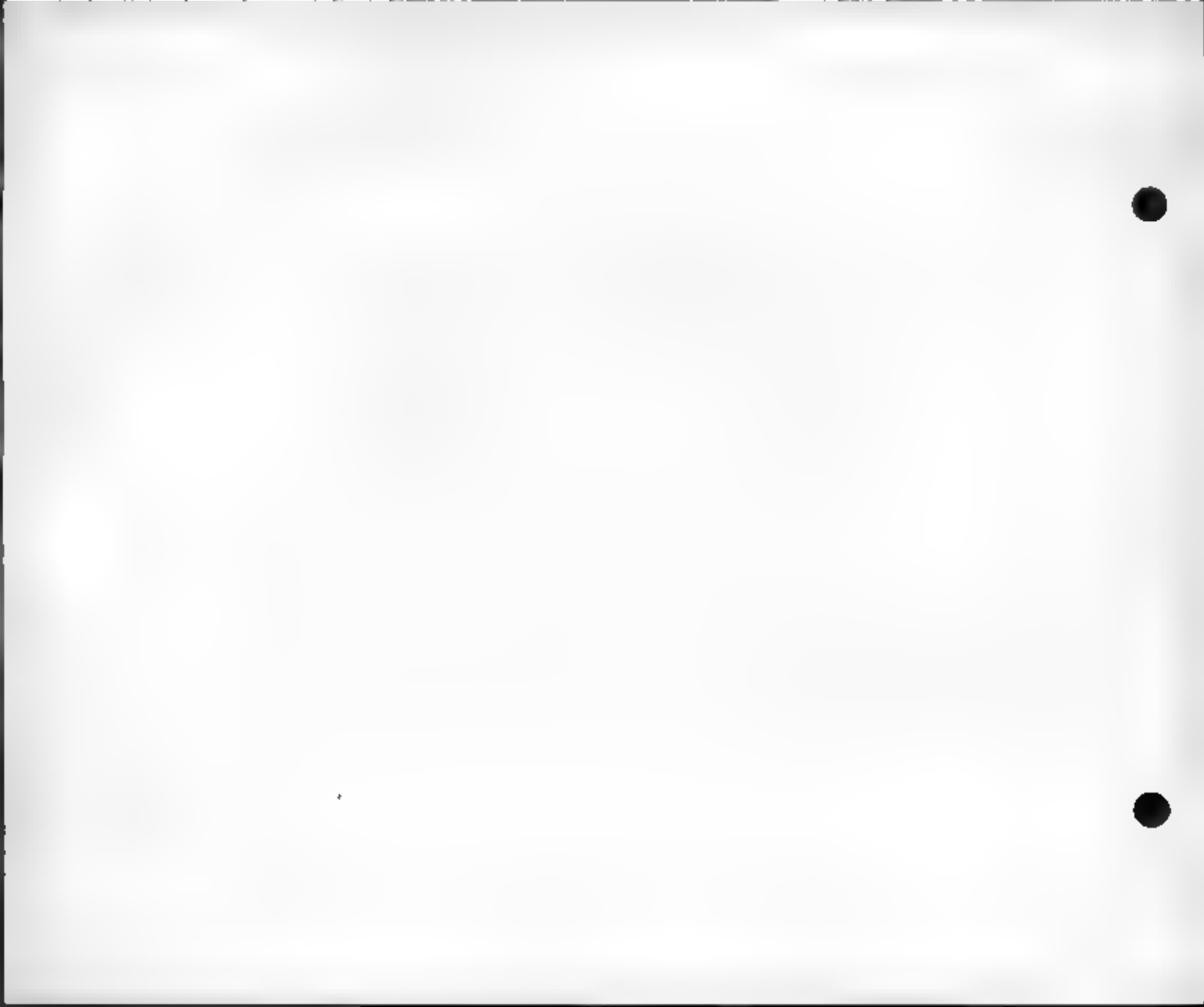
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07924

CERTIFICATE OF DEATH

07907

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN Catonsville c LENGTH OF STAY IN b 4yr 4mth 26dys		2 USUAL RESIDENCE (Where deceased lived. Institution Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN Baltimore	
3 NAME OF DECEASED Type or print Luster R. Thigpen		4 DATE OF DEATH Month June Day 9 Year 1967	
5 SEX male 6 COLOR OR RACE white 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH Oct. 14, 1908		9 AGE in years 58 10 UNDER 24 YEARS Months 1 Days 1 Hours 1 Mins 1	
11a TYPE OF OCCUPATION (Give kind of work done during past 12 months, working or life even if retired) printer		11b KIND OF BUSINESS OR INDUSTRY Maryland	
12 FATHER'S NAME Luther Thigpen		13 MOTHER'S MAIDEN NAME Loreen Holland	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes 15 SOCIAL SECURITY NO 6 6 563 639		16 217-12-9197 Records: SPRING GROVE STATE HOSPITAL	
17 IS CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Coronary occlusion with myocardial infarction Conditions if any which gave rise to immediate cause, stating the underlying cause last (b) Arteriosclerotic cardiovascular disease PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE (c) INTERVAL BETWEEN ONSET AND DEATH		18	
19a IDENTIFY UNDERLYING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20a TIME OF INJURY Month Day Year June 9 1967		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of item 18.) 20c INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 20d PLACE OF INJURY Home, farm, factory, street, office, bldg., etc. Home	
21 I certify that (this hospital attended the deceased from Jan. 13 1966 to June 9 1967 that the last saw the deceased alive on June 9 1967 and that death occurred at home and on the date stated above)		22a SIGNATURE Stella Wachslar 22b DATE SIGNED 6-9-67	
22c PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a BURIAL OR REMOVAL (Specify) Burial		23b DATE THEREOF 6/14/67	
24 FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. Balt. Md.		25 RECEIVED BY REGISTRAR JUN 16 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

27925

CERTIFICATE OF DEATH

7003

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete page 4, which should be filed with the State Dept. of Health prior to burial, cremation, or removal and interment, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		2 USUAL RESIDENCE (Where deceased lived) b. STATE <u>MARYLAND</u> c. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>		d. STREET ADDRESS <u>4804 Gateway Terr.</u>	
3 NAME OF DECEASED Type or print: <u>Charles Richard Thompson</u>		4 DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/2/97</u>
9 AGE in years <u>70</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Minutes <u>0</u>		10 BIRTHPLACE (County & State or foreign country) <u>Lynchburg VA</u>	
11a. K. A. OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Mechanic</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Assoc. Transport</u>	
12 FATHER'S NAME <u>George Thompson</u>		13 MOTHER'S MAIDEN NAME <u>Nettie Viola GRAINER</u>	
14 WAS DECEASED EVER IN ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>WW I</u>		15 SOCIAL SECURITY NO <u>225-10-1177</u>	
16 INFORMANT <u>Mrs. Ollie G. Thompson</u>		17 ADDRESS <u>4804 Gateway Terr 21227</u>	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> CONDITIONS (any which gave rise to immediate cause, or, stating the underlying cause) (b) <u>Carcinoma Oesophagus</u> HAS (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u></u>			
20a. AIT DEATH WAS INDETERMINATE? <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (NEITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II at item 8)	
20c. TIME OF INJURY Month, Day, Year <u>6/1/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. City or town <u></u> County <u></u> State <u></u>
21 I certify that (1) this hospital attended the deceased from <u>5/5/67</u> to <u>6-1-1967</u> and that death occurred at <u>9:00 PM</u> , from cause, and on the date stated above			
22a. SIGNATURE <u>Ran K. CHILLAR</u>		22b. ADDRESS <u>Chr. Balto. Med. Center Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/67</u>	
23c. NAME OF CEMETERY OR REMOVAL ADDRESS <u>Springhill Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Lynchburg Virginia</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		25a. REG'D BY REG'N. RAR <u>JUN 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



A. HEE VAN DE

Georgia

U.S.A.

William H. Thompson

Minerva Harrell

U WAs 0t eAdD EVER IN AMEC CURC S 0 0 A Jz 18 TV NL INFORMANT Address

Yes WWII 212 -01 7560A Mrs. Helen M. Thompson 831 Kellogg Rd. 21093

PAR DEATH HAS A DEL BY MYOCARDIAL INFARCTION
IMMEDIATE AL F.

111 K. T.

Condition: if any which
gave rise to immediate action
is stating the underlying
cause and

=AR JI C HER SIGNIF AN NDI O G ON R B I T I O T O A T 2 2 40 T K I A T L O D Y E S W A L A C L D J I V N P A R A 9 W A J A O D S Y
 P F R L N W
 YES ☐ NO ☐

6 08 YTFENA 1 A SF U-05 ZDB -FJ RIB ICW IN BY "C 16FM 7 0 7P 0 0' 4 Fe C FarL em

KRMARY W JN RIBL
A SF OFD ATH

206. NAME OF IN. TRY AAO A A31 2 4 RY K 4 5 A IS 34 Home 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

27. I certainly can take charge of the team and in advance he is willing to ☐. He is on ☒ in my ☒ of my own opinion.

ACTUAL

EXAMINER'S
NAME _____

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

Burial 6/28/67

Parkwood Cemetery

Parkville, Maryland

2.1. UNCLASSIFIED: DIRECTOR

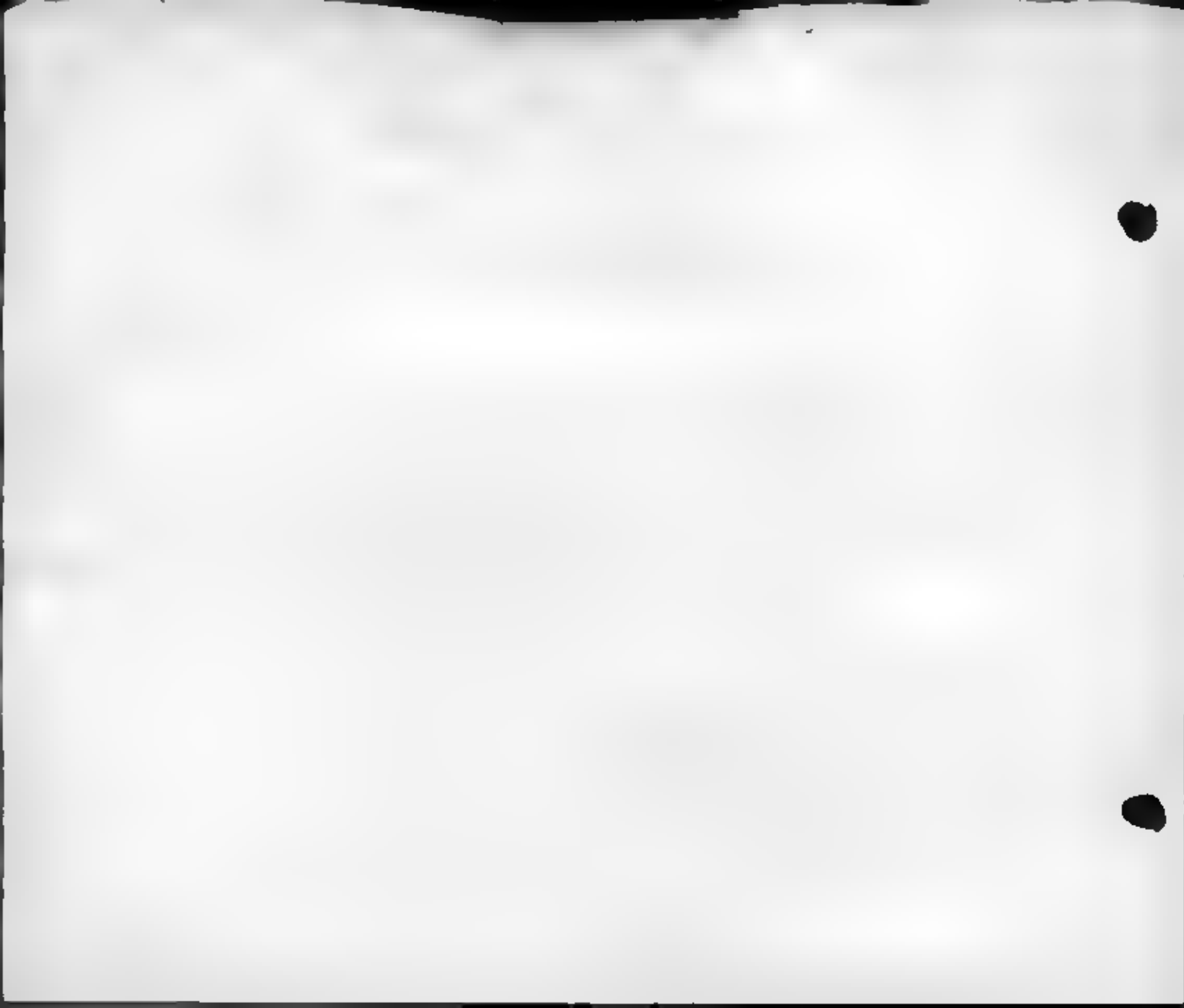
4b RF OBY REG STRAD RF TEAR GNATJE

VR AISME
SM 1/62

Wm. Cook-Brooks Towson 1050 York Rd. 21204

JUN 28 1967

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

07927

CERTIFICATE OF DEATH

07110

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN IF outside corporate limits write RURAL and give nearest town <u>Mt. WILSON</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence here is different) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN IF outside corporate limits write RURAL and give nearest town <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address <u>Mt. Wilson State Hospital</u>		e STREET ADDRESS <u>1937 Ramsay St, 23</u>	
3 NAME OF DECEASED Type of sex <u>M</u> a COLOR OR RACE <u>W</u> b MARRIED <input checked="" type="checkbox"/> <u>Joseph Kennard Thompson</u> c WIDOWED <input type="checkbox"/> <u>12/12/1913</u>		DATE OF DEATH <u>JUNE 14, 1967</u>	
4a "SINCE DEATH" IN Give kind of work done <u>Brakeman</u> b KIND OF BUSINESS INDUSTRY <u>Patapeco & River RR</u> c BIRTHPLACE, County & State <u>PENNA</u> d MOTHER'S MAIDEN NAME <u>LITNER, GRACE</u>		5 CAUSE OF DEATH Enter only one cause per line for a, b, and c PART I DEATH WAS CAUSED BY a IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> b CONDITION if any which gave rise to immediate cause (b) <u>FAR ADVANCED PNEUMONARY TB.</u> c Noting the underlying cause last (c) <u>9 Ys.</u>	
6 PAR II OTHER SIGNIFICANT CONDITIONS: CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONTRIBUTION GIVEN IN PAR I) a 27a a. DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER b 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a; Part b if item 8) c 20c INJURY OCCURRED d 20d PLACE OF INJURY Home or other place (If injury occurred on any street give address)		7 27b SIGNATURE OF PHYSICIAN <u>W. Newcomer</u> M.D. ATTENDING PHYSICIAN NAME <u>Wm. Newcomer, M.D., Supt.</u> ADDRESS <u>Mt. Wilson, Maryland</u>	
8 27c SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		9 27d SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
10 27e SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		11 27f SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
12 27g SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		13 27h SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
14 27i SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		15 27j SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
16 27k SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		17 27l SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
18 27m SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		19 27n SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
20 27o SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		21 27p SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
22 27q SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		23 27r SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
24 27s SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		25 27t SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
26 27u SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		27 27v SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
28 27w SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		29 27x SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	
30 27y SIGNATURE OF REGISTRAR <u>John J. Johnson</u>		31 27z SIGNATURE OF REGISTRAR <u>John J. Johnson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to be used as the burial-transit permit. Then please remove to burier. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal and in no event within 72 hours after death.

DATE JUN 16 1967

SIGNATURE OF REGISTRAR
John J. Johnson

J 1 .

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07928

07311

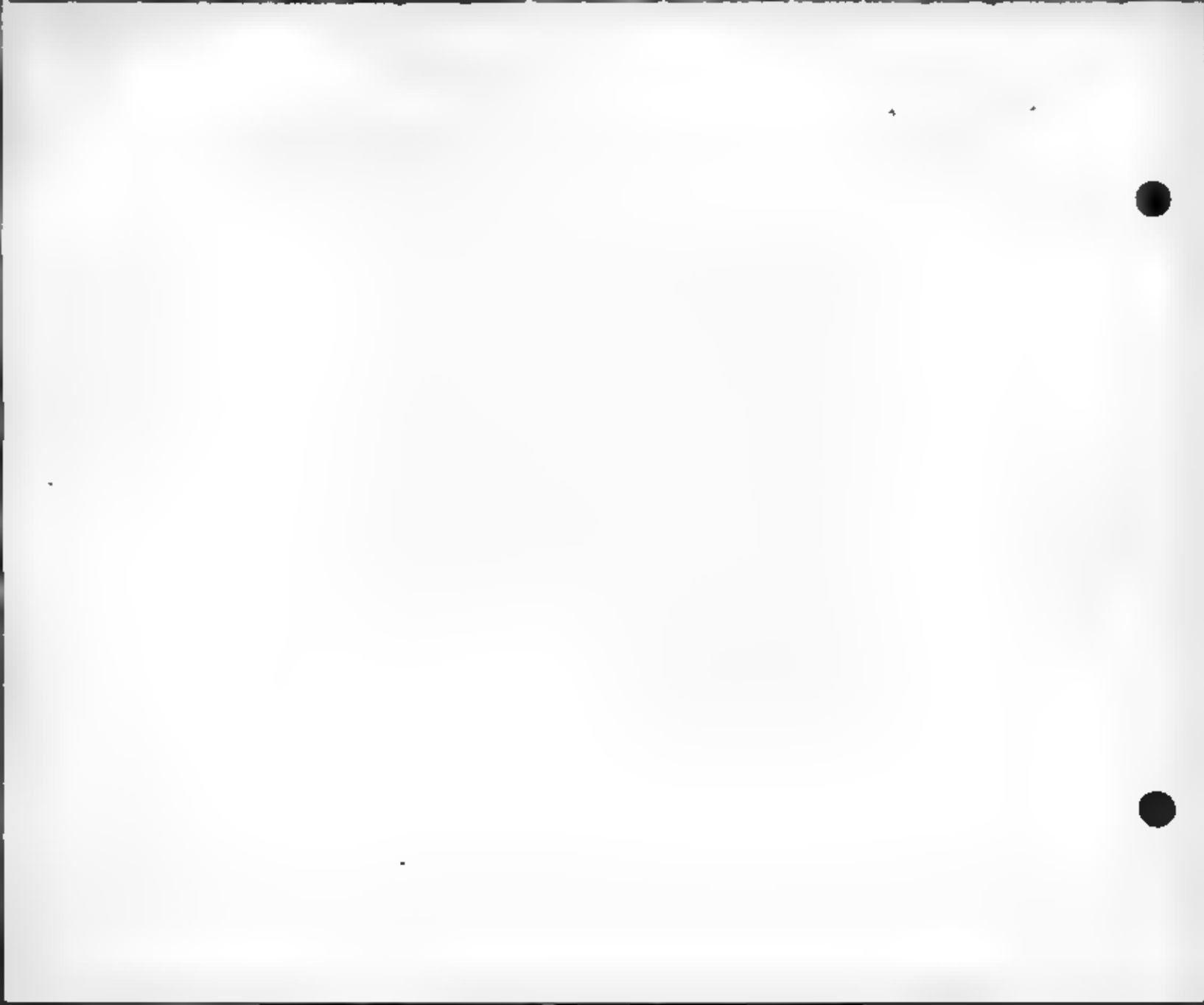
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUA. RESIDENCE Where deceased lived, if institution. Residence before admission a. STATE Maryland b. COUNTY	
b. CITY OR TOWN If outside corporate limits write RURAL and give nearest town Towson		c. CITY OR TOWN If outside corporate limits write RURAL and give nearest town Baltimore - 21234	
d. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address St. Joseph Hospital		e. STREET ADDRESS 1806 Cromwood Road	
3 NAME OF DECEASED Type of print Dora Marian Townsley		4 DATE OF DEATH Month June Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-27-96
9 AGE In years Months 70 Days 15 Years 70		10 FUNDING YEAR Month June Day 15 Year 1967	
11 OCCUPATION Give kind of work done during most of working life (even if retired) Homemaker		12 KIND OF BUSINESS OR INDUSTRY Own Home	
13 BIRTHPLACE County & state or foreign country Harford Co., Maryland		14 TEN OF WHAT COUNTRY U.S.A.	
15 FATHER'S NAME William Blakley		16 MOTHER'S MARRIED NAME Sarah L. Smith	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give unit and dates of service) NO		18 SOCIAL SECURITY NO. 220-30-0104	
19 INFORMANT William P. Townsley		Address 21236	
20 B. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE Carcinoma of Right Lung with Metastasis to Liver		INTERVAL BETWEEN ONSET AND DEATH	
21 CONDITION (if any) which gave rise to immediate cause or stating the underlying cause Due to		22 DUE TO	
23 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1			
24a. ACCIDENT WAS UNDER MINOR OR IN REPAIR? A. YES B. NO IF OTHER NOTIFY MEDICAL EXAMINER		24b. DESCRIBE HOW INJURY OCCURRED (brief nature of injury in Part 1 or Part 2 or item 18)	
25. TIME OF INJURY Month Day Year Hour min p.m. June 15 1967		26. NATURE OF INJURY While on work <input type="checkbox"/> Not while on work <input type="checkbox"/>	
27. PLACE OF INJURY Home (give address) Factory street office bldg. etc.		28. CITY or town State	
29 I certify that if this hospital attended the deceased from May 21, 1967 to June 15 1967 that I was last saw the deceased alive on June 15, 1967 and that death occurred at 5:10 A.M. from cause and on the date stated above			
27a. SIGNATURE Freidoon Malek M.D.		27b. DATE SIGNED June 15, 1967	
28a. PHYSICIAN'S NAME (print) Freidoon Malek M.D.		28b. ADDRESS 7600 York Road, Towson - 21204, Md.	
29a. BURIAL REMAINDER REMOVAL (print) burial	29b. DATE THEREOF 6-17-1967	29c. NAME OF CEMETERY OR CREMATORY Del Air Memorial Cemetery	29d. CITY or town State Del Air Md.
30. FUNERAL DIRECTOR		31. DEATH BY REGISTRATION DATE June 19 1967	
32. SIGNATURE		33. SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove a den paper, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours of the death.



Form No. 10-67

21. RICHARD AL. CHESTNUT DR., 230 REMOVAL (Specify)	22. DATE THEREOF	23. NAME OF CEMETERY OR CREMATORY	24. LOCATION (City, town or county)	(See e)
Burial	June 97	Dried Ridge Cem	Pikesville, Md	
25. JOURNAL DIRECTOR	ADDRESS		25a. REC'D BY REC STRAR	25b. REGISTRAR'S SIGNATURE
B. Roger General Hq	3631 Falls Rd		JUN 20 1967	[Signature]
By [Signature]	[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to bar papers. Pages 1-2 should be filed with the State Dept. of Health prior to burial, cremation or entombment, and page 4 with the local health department.

VR 115
25M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07013

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" Fort Howard		2 USUAL RESIDENCE "Where deceased lived if institution. Residence before admission" c STATE Maryland d CITY OR TOWN "If outside corporate limits write RURAL and give nearest town" Baltimore	
3 NAME OF HOSPITAL OR INSTITUTION "If not in hospital give street address" Veterans Administration Hospital		4 STREET ADDRESS 723 N. Glover Street	
5 NAME OF DECEASED First CLARENCE Middle DAVID Last TRAVITS		6 DATE OF DEATH Month June Day 23 Year 1967	
7a SEX Male	7b COLOR OR RACE White	7c MARRIAGE MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9/11/1900
9a OCCUPATION "Give kind of work done during last year of working life, even if retired" Welder		9b KIND OF BUSINESS OR INDUSTRY Shipyard	
10a BIRTHPLACE (County & State of foreign country) Harrisburg, Pa.		10b YES IF WHAT U.S.A.	
11 NAME OF DECEASED'S MOTHER Wilson Travits		11 NAME OF DECEASED'S FATHER Edna Klinger	
12a DECEASED EVER IN ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) WWI		12b SOCIAL SECURITY NO. 188 05 10 14	
13 CAUSE OF DEATH "List in one group per line for a, b, and c." PART I: DEATH WAS CAUSED BY MYOCARDIAL INFARCTION Condition of any which gave rise to immediate cause, a, stating the underlying cause last ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		13b INTERESTING CAUSE OF DEATH 6 years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. ONE OR MORE GIVEN IN PART I			
20a AGE OF DECEASED WHEN INJURY OCCURRED (Enter number of years in Part a of Part II of Item 18.) 66		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a of Part II of Item 18.) Heart attack	
21a INJURY OCCURRED Month June Day 21 Year 1967 Hour 6:35 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>		21b INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/>	
21c PLACE OF INJURY Home (Home, farm, factory, street, office, bldg, etc.) Home		21d CITY OR TOWN Baltimore	
21 certify that this hospital attended the deceased from June 21, 1967 to June 25, 1967 that (X) we last saw the deceased alive on June 25, 1967 and that death occurred at 6:35 PM from causes and on the date stated above.			
22a SIGNATURE PUSHPENDRA SENAN		22b DATE SIGNED 6/25/67	
22c PHYSICIAN'S NAME Type PUSHPENDRA SENAN, M.D.		22d ADDRESS VA Hospital, Fort Howard, Md.	
23a BURIAL CREMATION (Specify) Burial	23b DATE OF BURIAL 6/27/67	23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d LOCATION (City or Town) County State Baltimore, Maryland
24 FUNERAL DIRECTOR H. Sander Funeral Home		25 RECORD BY REGISTRAR John J. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

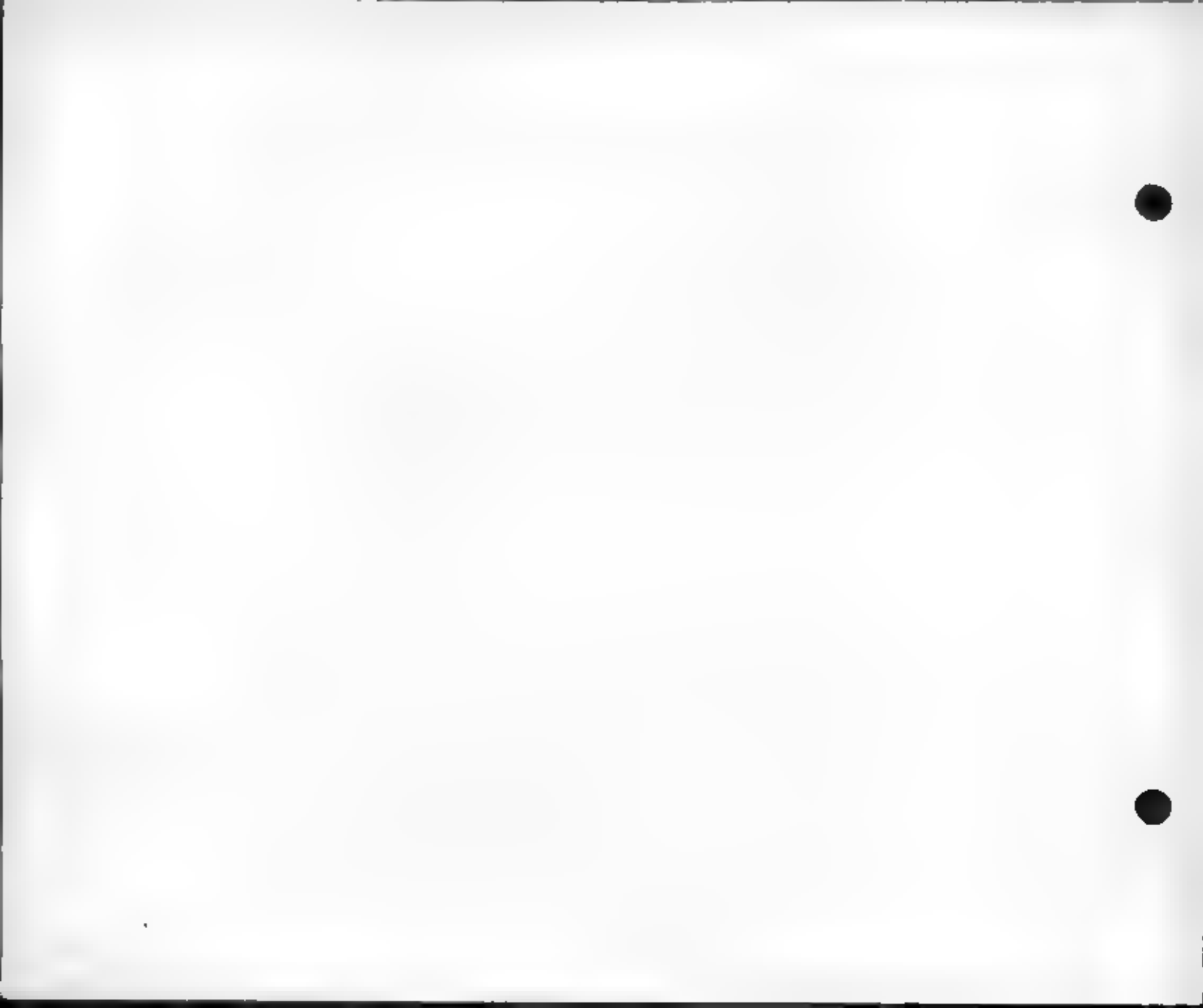
07931

CERTIFICATE OF DEATH

07914

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN IF outside corporate limits, write RURAL and give nearest town Rosedale c. LENGTH OF STAY IN b 7910 1/2 33rd St.		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN IF outside corporate limits, write RURAL and give nearest town Rosedale d. STREET ADDRESS 7910 1/2 33rd St.	
3 NAME OF DECEASED First Middle Last JENNIE C. TROMPETER-KING		4 DATE OF DEATH Month Day Year June 30 1967	
5 SEX female	6 COLOR OR RACE white	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/3/95
9 AGE (In years, months, days, hours, minutes) 72		10 IF UNDER 1 YEAR Months Days Hours Minutes 72	
11a. OCCUPATION (Give kind of work done during life, if working life ever entered) housewife		11b. KIND OF BUSINESS OR INDUSTRY at home	
12. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		13. IN OF WHA COUNTRY?	
14. FATHER'S NAME John Schwartzmann		15. MOTHER'S MAIDEN NAME unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No or unknown) (If yes give war or dates of service) 214-16-9829A		17. INFORMANT Address Rose Marie Kluga, dght, above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Artery Disease CONDITIONS (b) which gave rise to immediate cause (a) stating the underlying cause DUE TO Arteriosclerosis LAST (c) Arteriosclerosis			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISORDER (CONDITION GIVEN IN PART I) Diabetes Mellitus, Hypertension, Atherosclerosis, etc.			
19a. AT DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER) Myocardial Infarction		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20c. PLACE OF INJURY Home farm, factory, street, office, bldg., etc.	20d. (City or town) (County) (State) Baltimore, Md.
21. I certify that () this hospital attended the deceased from 2/3/36 to 6/30/67 that () we last saw the deceased alive on 6/30/67 and that death occurred at 11:30 A.M. from causes and on the date stated above			
22a. SIGNATURE Dr. Joseph R. Liberto		22b. DATE SIGNED 6/30/67	
23a. BURIAL REMOVAL (Specify) Burial		23b. DATE OF BURIAL 7/3/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL HOME (Name and address) Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY R-GIN BAR JUL 3 1967	
		25b. REGISTRAR'S SIGNATURE Michael J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director for page 3 should be detached for use as the burial permit. Then please remove all other papers, pages and show, to be filed with the State Dept. of Health prior to burial. Removal or removal and any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MS 415 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND
07932
CERTIFICATE OF DEATH
07915

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY (in 15) <u>15</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>Fullerton Heights Ave.</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen E. Turminello</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/1888</u>		9. AGE (in years last birthday) <u>78</u> yrs		10. IF FUNERAL 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		12. K NO OF BUSINESS OR INDUSTRY <u>Home</u>		13. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>5</u>		17. INFORMANT <u>Mr Dominic Turminello</u>		18. ADDRESS <u>3 Fullerton Heights Ave</u>	
19. FATHER'S NAME <u>Tobias Johnson</u>		20. MOTHER'S MAIDEN NAME <u>Ida Wells</u>		21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>		22. INTERVAL BETWEEN ONSET AND DEATH		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a). <u>NO</u>		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER THAN BY MEDICAL EXAMINER) <u>NO</u>		26. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18.) <u>NO</u>	
27. TIME OF INJURY Month Day Year Month <u>19</u> Day <u>19</u> Year <u>1967</u>		28. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		29. PLACE OF INJURY (Home farm, factory, street, office bldg., etc) <u>Home</u>		30. (City or town) <u>Baltimore</u>		31. (County) <u>Baltimore</u>		32. (State) <u>MD</u>		33. I certify that (1) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>19</u> M from the causes and on the date stated above.		34. SIGNATURE <u>[Signature]</u>	
35. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		36. ADDRESS <u>[Address]</u>		37. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		38. DATE SIGNED <u>6/15/67</u>		39. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		40. DATE THEREOF <u>6-19-1967</u>		41. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		42. LOCATION (City town or county) <u>Baltimore City</u>	
43. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		44. ADDRESS <u>[Address]</u>		45. REC'D BY REG STRAB <u>[Signature]</u>		46. REG STRAB'S SIGNATURE <u>[Signature]</u>		47. DATE <u>JUN 19 1967</u>		48. [Signature]		49. [Signature]		50. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

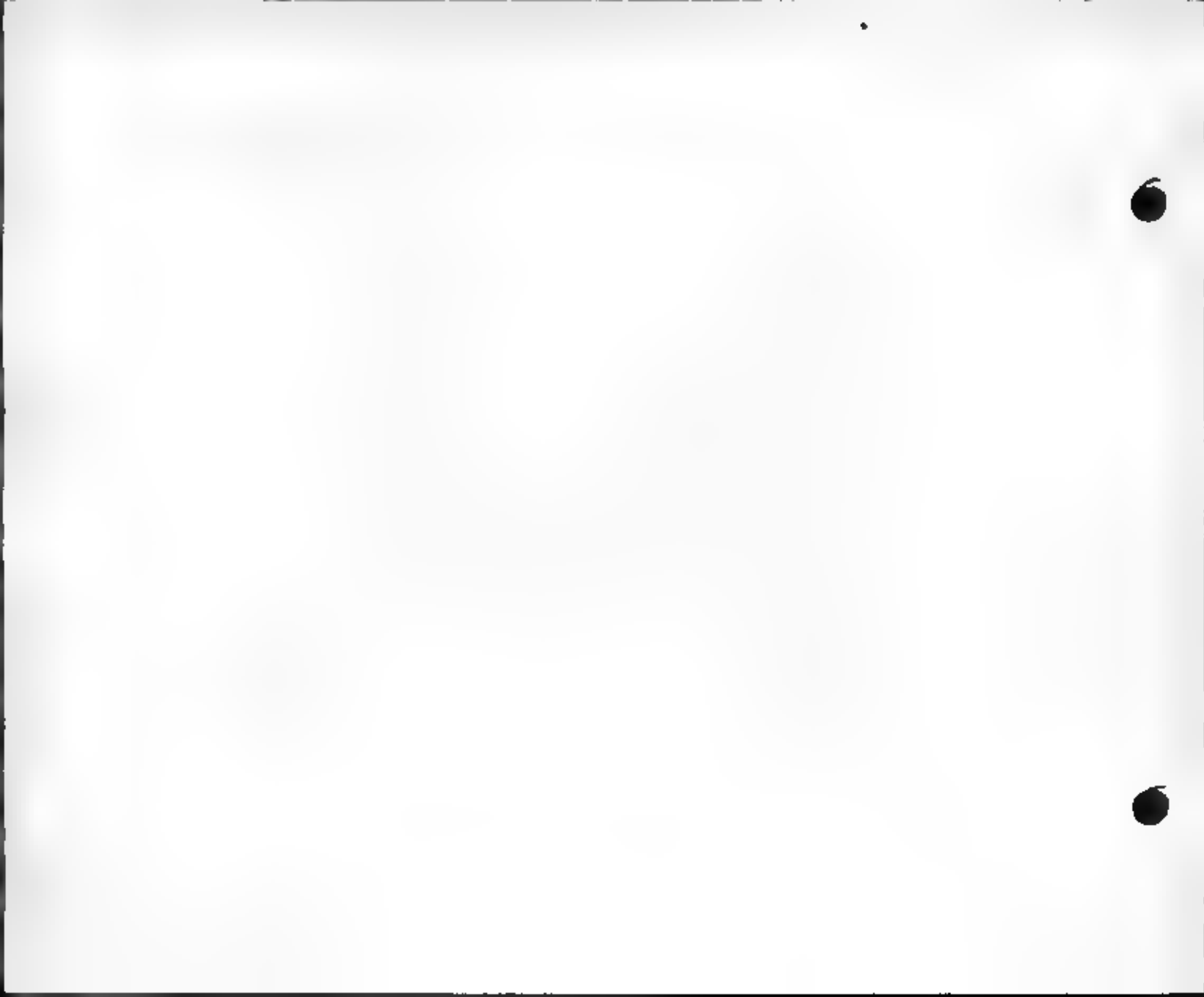
07934

07017

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if in institution, residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3443 Harwell Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS Baltimore, Maryland 21213	
3. NAME OF DECEASED (Type or print) EDWARD JOHN URBAN		4. DATE OF DEATH Month June Day 18 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-04
9. AGE yrs 63		10. IF BIRTHDAY Month _____ Day _____ Hour _____ Min _____	
11. USUAL OCCUPATION (Give kind of work done during past 6 working life event listed) Maintenance Foreman		12. KIND OF BUSINESS Regal Laundry	
13. FATHER NAME Anton Urban		14. MOTHER MAIDEN NAME Sophia Musil	
15. WAS DECEASED EVER IN ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) 216-07-5912		16. INFORMANT Address Anna Urban, wife, above	
17. CAUSE OF DEATH (Enter only one cause per line for a), b) and c) PART DEATH CAUSED BY 260X IMMEDIATE CAUSE (a) Cerebral vascular thrombosis DUE TO (b) Diabetes Mellitus DUE TO (c) _____ CONDITIONS (if any) which gave rise to immediate cause or, stating the underlying cause, _____		INTERVAL BETWEEN ONSET AND DEATH _____	
18. PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND THOSE GIVEN IN PART 17 _____		19. WAS A "COPY PERFORMANCE" YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ME OF INJURY (Month, Day, Year) Month _____ Day _____ Year 67		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 17 or Part 20a or item 18) _____	
20c. INJURY OR ILLNESS While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, tornitory, street, etc.) _____	
21. I certify that I) this hospital, attended the deceased from 6-11-67 to 6-18-67 that was last seen the deceased alive on 6-18-67 and the death occurred at 2:15 PM from causes and on the date stated above.		22. DATE SIGNED 6-18-67	
23a. PHYSICIAN'S NAME (Type) Fiorella Malit, M.D.		23b. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23c. BURIAL OR CREMATION Burial	23d. DATE THEREOF 6/22/67	23e. NAME OF CEMETERY OR BURIAL PLACE Holy Redeemer Cem.	23f. CITY OR TOWN Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. RECEIVED BY REGISTRAR JUN 20 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, file in by the funeral director. Page 3 should be attached to the death certificate. Then please send the death certificate, pages 1, 2, and 3 to the State Department of Health prior to burial, cremation or removal and in any other death.



TO DEPUTY MEDICAL EXAMINER

Particulars should be entered in the death certificate with the word "pending" in the "Cause of Death" column. If the death is pending, the certificate should be forwarded to the Chief Medical Examiner's Office along with the death certificate. The certificate should be forwarded to the Chief Medical Examiner's Office along with the death certificate. The certificate should be forwarded to the Chief Medical Examiner's Office along with the death certificate.

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: For the purpose of burial, the certificate should be forwarded to the funeral director. For the purpose of burial, the certificate should be forwarded to the funeral director. For the purpose of burial, the certificate should be forwarded to the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07935

07918

PLACE OF DEATH

Baltimore

MARYLAND

USUAL RESIDENCE WITHIN

Maryland

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard Hospital

Baltimore

606 N. Lakewood Avenue #5

NAME OF DECEASED

WILLIAM

VAN COURT

DATE OF DEATH

6

2

67

Male

White

MARRIED

NEVER MARRIED

DATE OF BIRTH

June 2, 1907

Laborer

Balto. City Sanitation Dept.

Balto., Md.

U.S.A.

William H. Van Court

Bernadine Herold

yes

WWII

118-18-0983

Lorraine Van Court, wife, Above

CAUSE OF DEATH

Acute Subdural Hematoma

4047

DUE TO

(Conditions, if any, which gave rise to immediate cause, a)

(b)

(c)

(c)

For

PRIMARY OR CONTRIBUTING

Allegedly fell

Unk 6/2/ 1967

Unknown

Baltimore, Md.

I certify that took charge of the body in the bed and have had it placed in the coffin and sealed it. I have also signed the death certificate and the medical examiner's certificate.

ACTUAL SIGNATURE

EXAMINER'S NAME

Werner U. Spitz, M.D.

DATE SIGNED

6/6/67

Funeral

6/6/67

Baltimore Cemetery

Balto., Md.

Schimmunek Funeral Home

2601-03-05 E. Madison Street #5

DATE

JUN 7 1967

DATE

JUN 7 1967

dear
... ..

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health prior to burial, cremation or removal, and none sent within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07936

07513

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN PALETTESVILLE		2. USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
3. TYPE OR FLOWN (If outside corporate limits write RURAL and give nearest town) CARDASVILLE		4. LENGTH OF STAY IN b. 40 YRS.	
5. NAME OF HOSPITAL OR INSTITUTION (Not in hospital, give street address) SPRING GROVE STATE HOSP		6. STREET ADDRESS 29 BALTAIRE AVE	
7. NAME OF DECEASED Type in print First Middle Last EDITH ROSS VACANT		8. DATE OF DEATH Month Day Year June 20 1967	
9. SEX FEMALE	10. COLOR OR RACE WHITE	11. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH 7-9-16
13. AGE at last birthday 68		14. IF UNDER 24 HRS. Months Days Hours Min 4 5 1	
15. MAJOR OCCUPATION (Give kind of work done during max. 2 working life even if retired) HOUSEWIFE		16. KING OF BUSINESS OR INDUSTRY HOUSEWIFE	
17. BIRTHPLACE (County & State or foreign country) BALTIMORE		18. IF TYPE OF WHAT U S A	
19. FATHER'S NAME CHARLES DERRY ROSS		20. MOTHER'S MAIDEN NAME KATE EDNA MACK	
21. WA. OF DEATH EVER IN ARMED FORCES (Yes, no, if not, give date of service) NO		22. SOCIAL SECURITY NO. 213/28/0459	
23. CAUSE OF DEATH (Enter only one cause per line a, b, and c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis		24. INTERVAL BETWEEN ONSET AND DEATH	
25. PART II: OTHER SIGNIFICANT CONDITIONS OR SIGNS LEADING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE Probable bilateral melanosis		26. IS THERE ANOTHER CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. a. DATE OF INJURY OR ONSET OF DISEASE (If either NOTIFY MEDICAL EXAMINER) 6/20/67		28. b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 8)	
29. TIME OF INJURY Month Day Year June 20 1967		30. INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input type="checkbox"/>	
31. PLACE OF INJURY Home farm factory street, a fire, etc. Spring Grove State Hospital		32. CITY OR TOWN County State BALTD. Co. Md.	
33. I certify that this hospital attended the deceased from 12-21-966 to 6-20-67 and that death occurred on 6-20-67 at 8:50 PM from causes and on the date stated above.			
34. SIGNATURE Narciso W. Carmona MD		35. DATE SIGNED 6/20/67	
36. PHYSICIAN NAME Type NARCISO W. CARMONA		37. ADDRESS Spring Grove State Hospital	
38. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>		39. NAME OF MURDER OR RIMATORY GRAND FAITH	
40. DATE OF BURIAL 6/23/1967		41. NAME OF MURDER OR RIMATORY BALTD. Co. Md.	
42. NAME OF REGISTAR W. B. Bradley - Dundalk Md.		43. NAME OF REGISTAR W. B. Bradley - Dundalk Md.	
44. NAME OF REGISTAR W. B. Bradley - Dundalk Md.		45. NAME OF REGISTAR W. B. Bradley - Dundalk Md.	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

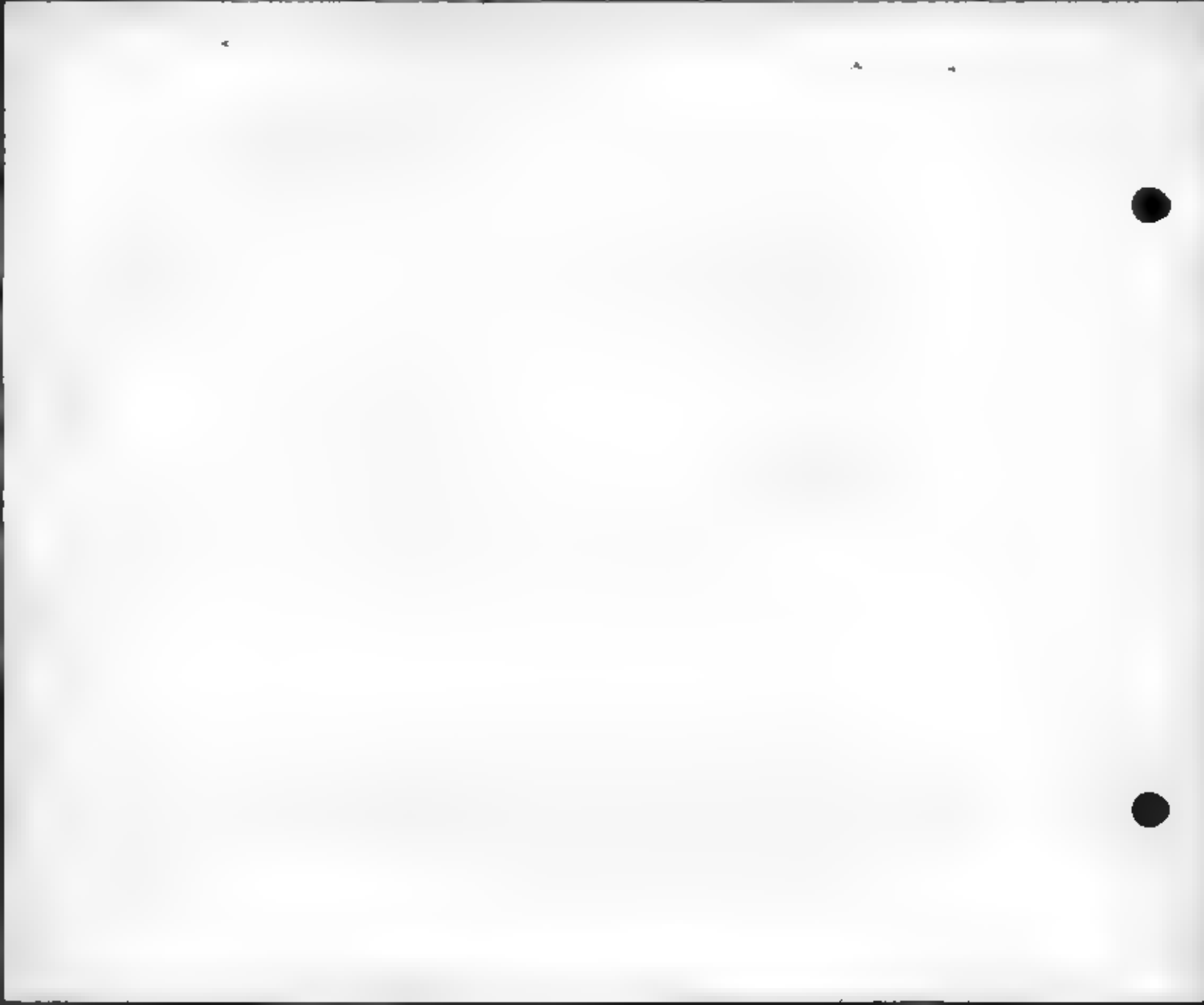
07937

CERTIFICATE OF DEATH

1700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 shall be delivered to the Baltimore Health Department. The funeral director shall be filed with the State Department of Health. Page 4 shall be filed with the State Department of Health. Page 5 shall be filed with the State Department of Health.

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN FORT HOWARD c OUTSIDE CORPORATE LIMITS, write RURAL and give nearest town		2 USUAL RESIDENCE (Where deceased lived at institution before admission) a STATE MARYLAND b COUNTY	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL		e STREET ADDRESS 1300 N. KENWOOD AVENUE	
3 NAME OF DECEASED Type or print First Middle Last GEORGE G. WALLACE		4 DATE OF DEATH Month Day Year JUNE 4, 1967	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/19/36
9 AGE in years Month Day Years 31		10 IF UNDER 24 YEARS Months Days Hours Mins 0 0 0 0	
11a PLACE OF BIRTH (Write kind of work done during most of working life, even if retired) PRINCESS ANNE, MARYLAND		12 7th of WHAT COUNTRY U.S.A.	
13 OTHER NAME GLENWOOD WALLACE		14 MOTHER'S MAIDEN NAME ANNA MAE MILLS	
15 WHERE DECEASED (In or out of home) Yes, no, if unknown (If yes give age at date of service) YES 11		16 JOE or if CITY NO 20 32 83 1	
17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		18 ADDRESS CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
19 CAUSE OF DEATH (List only one cause per line for a, b, and c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANEMIA, PNEUMOCOCCAL, BILATERAL DUE TO b BLASTIC CRISIS DUE TO c CHRONIC MYELOGENOUS LEUKEMIA		20 YEARS 3	
21 PAR II OTHER SIGNIFICANT CONDITION: CHRONIC MYELOGENOUS LEUKEMIA		22 OTHER SIGNIFICANT CONDITION: CHRONIC MYELOGENOUS LEUKEMIA	
23a AUCER WAS UNDERLYING OR CONTRIBUTING TO DEATH IF OTHER BY MEDICAL EXAMINER	23b DESCRIBE HOW INJURY OR DISEASE CAUSED DEATH (If injury or disease not listed in Part II of item 18)	24 OTHER SIGNIFICANT CONDITION: CHRONIC MYELOGENOUS LEUKEMIA	
25 TIME OF DEATH Month Day Year Hour min pm 6-9-67	26 INJURY OR DISEASE While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	27 PLACE OF INJURY Home, farm, factory, street, other (Specify)	28 CITY or town State 6,5,67
21 I certify that (a) this hospital attended the deceased from 5/12/67 to 5/14/67 and saw the deceased die on 5/14/67 and that death occurred 9:30 P.M. from causes and on the date noted above.		22 SIGNATURE OF PHYSICIAN HEILON NEILSON, M.D.	
23 PHYSICIAN'S NAME Type HEILON NEILSON, M.D.		24 ADDRESS VAH FORT HOWARD, MARYLAND	
25 BURIAL OR REMOVAL REMOVAL SPECIFY 1300	26 DATE INTERRED 6-9-67	27 NAME OF CEMETERY OR REMOVAL POLK ROAD CHURCH CEMETERY	28 CITY or town State PRINCESS ANNE, MARYLAND
29 FUNERAL DIRECTOR ELROY O. WILSON		30 ADDRESS 2004 ORPHEANS ST. BALTIMORE, MD.	



1
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, detach page 3 and deliver it to the funeral home. The funeral home will deliver it to the State Department of Health. The funeral home should be filled with the State Dept. of Health prior to burial, cremation or removal and transportation within 72 hours after death.

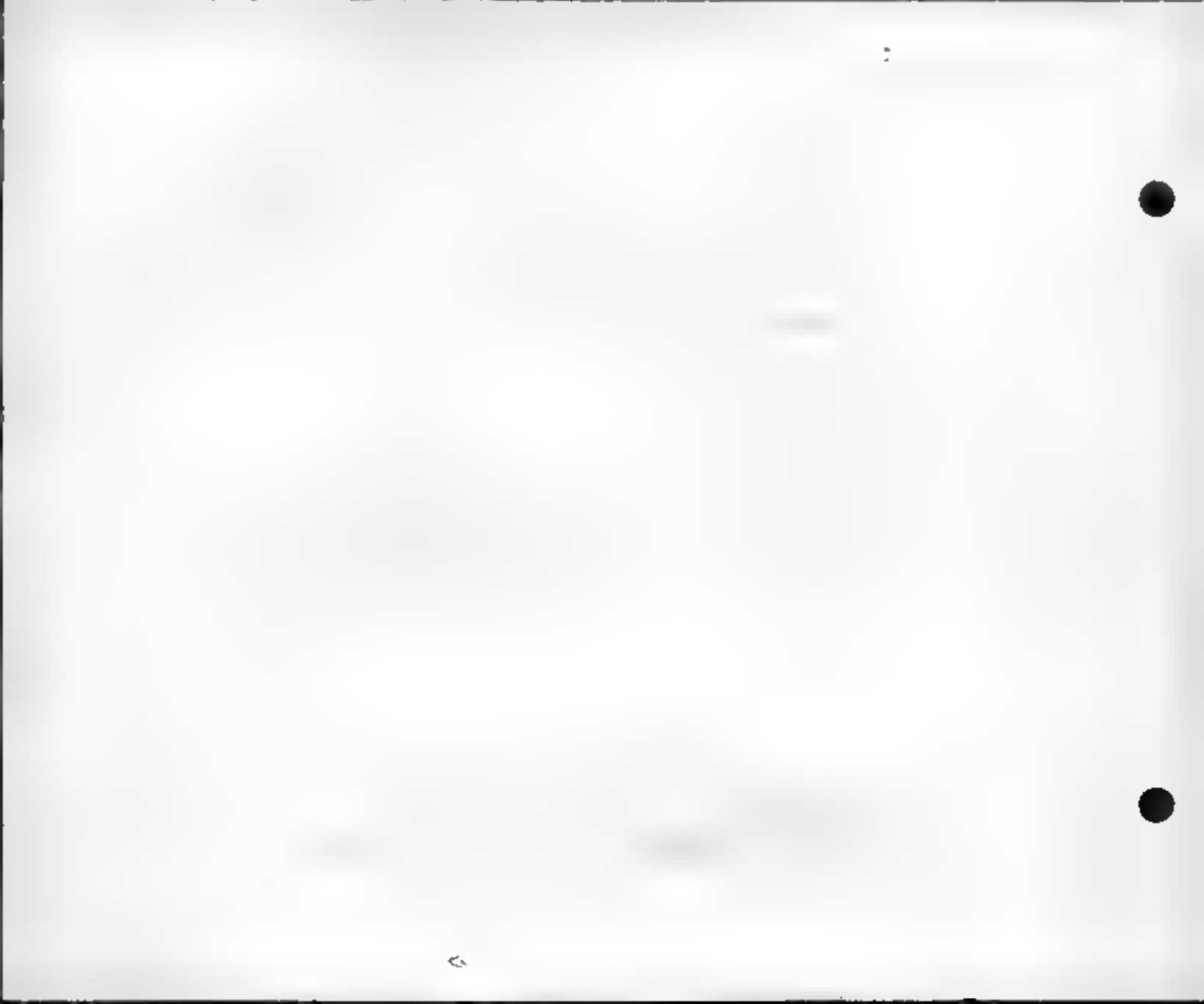
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07938

CERTIFICATE OF DEATH

07021

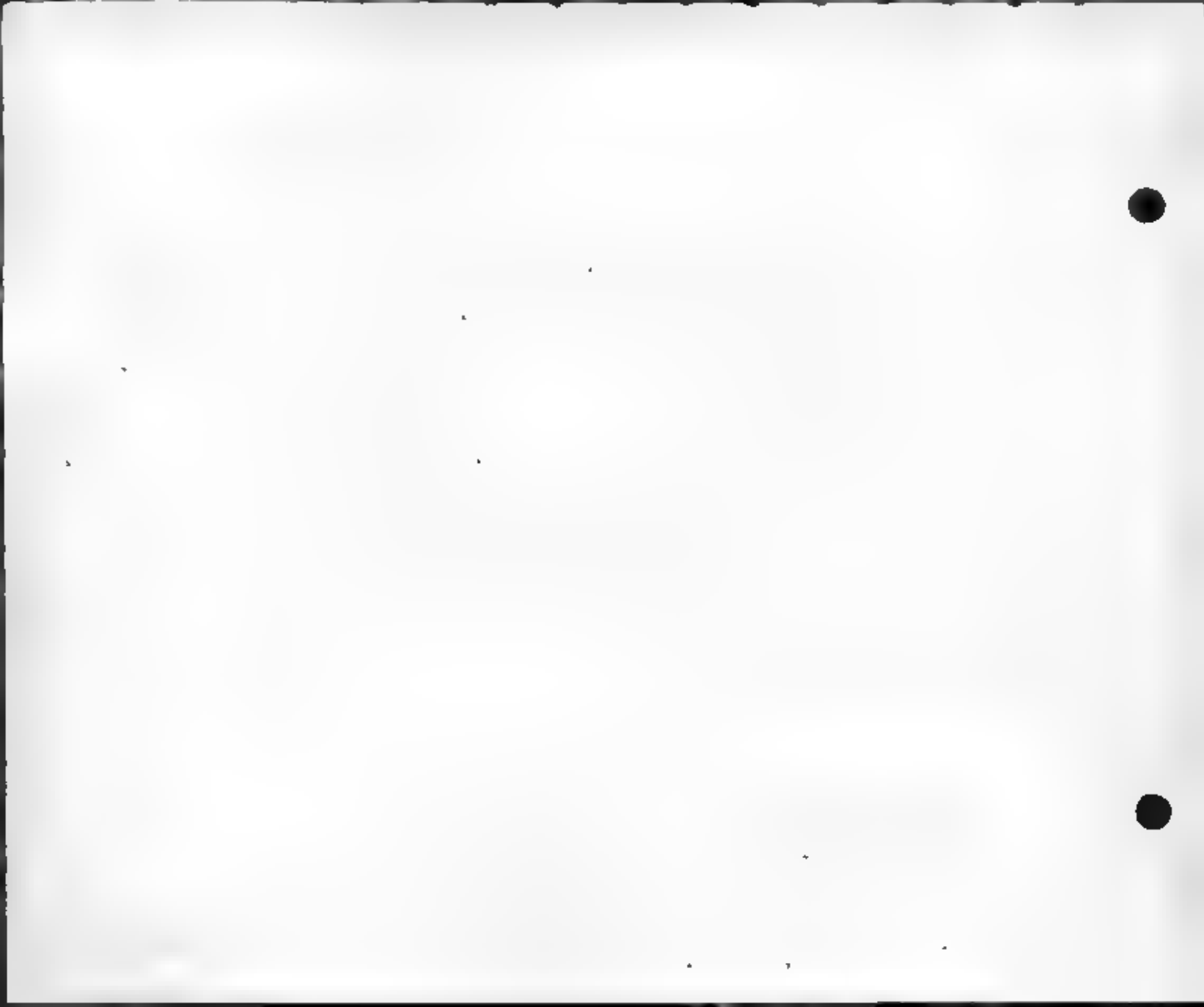
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN <u>Randallstown</u> c. RURAL OR SUBURBAN <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION <u>Baltimore General Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN <u>WOODLAWN</u> d. STREET ADDRESS <u>6417 LEHART ST</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3 NAME OF DECEASED a. FIRST NAME <u>William</u> b. MIDDLE NAME <u>P</u> c. LAST NAME <u>Waters</u> d. SEX <u>M</u> e. COLOR OR RACE <u>White</u> f. MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		4 DATE OF DEATH a. YEAR <u>1967</u> b. MONTH <u>6</u> c. DAY <u>19</u> d. TIME OF DEATH <u>7:00 PM</u>	
5a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u> b. KIND OF BUSINESS OR INDUSTRY <u>?</u> c. BIRTHPLACE (County & State or foreign country) <u>MD</u> d. ZIP CODE <u>21202</u>		6. AGE IN YEARS <u>70</u> 7. IF UNDER 1 YEAR a. MONTH <u>1</u> b. DAY <u>19</u> c. HOUR <u>7</u> d. MINUTE <u>00</u>	
8. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) a. PART DEATH DUE TO <u>VENTRICULAR FIBRILLATION</u> b. IMMEDIATE CAUSE <u>0 to Arteriosclerosis</u> c. CONDITION (any which gave rise to immediate cause or stating the underlying cause) <u>Y231</u> d. DUE TO <u>DU TO</u>		9. INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
10. PAR. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (c) <u>?</u>			
20a. INJURY WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. DATE OF INJURY Month Day Year Hour: <u>9</u> PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg, etc.		20f. CITY OR TOWN (County) (State)	
21. I certify that (this hospital attended the deceased from <u>6-14-1967</u> to <u>6-19-1967</u>) that (1) we, last saw the deceased alive on <u>6-19-1967</u> and that death occurred at <u>7:00 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A. E. STANBURY, JR.</u>		22b. DATE SIGNED <u>6-19-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Baltimore County Gen Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL, SPECIAL <u>?</u>		23b. DATE OF BURIAL <u>6/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NOTTINGHAM CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>CORLEA CREEK MD</u>	
24. FUNERAL DIRECTOR <u>J. T. STANBURY</u>		25. REC'D BY REGISTRAR <u>BALTO MD</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 23 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND																											
<div style="display: flex; justify-content: space-between;"> 7933 Item 320 & 321 CERTIFICATE OF DEATH 11922 </div>																											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>						2. USUAL RESIDENCE (Where deceased lived, 1 institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>Towson Convalescent Home</u>																					
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>M.</u> Last <u>Watkins</u>						4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>																					
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 22, 1882</u> 9. AGE (in years last birthday) <u>84</u> yrs						10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																					
13. FATHER'S NAME <u>Joseph E. Watkins</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Macatee</u>																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>213-18-6522</u> 17. INFORMANT <u>Mrs. David Tillman</u> Address <u>Towson 4, Md.</u>																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																											
<table border="1"> <thead> <tr> <th>PART</th> <th>DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</th> <th>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST</th> <th>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</th> </tr> </thead> <tbody> <tr> <td>1</td> <td><u>4201</u></td> <td><u>Coronary, cerebral and generalized arteriosclerosis</u></td> <td><u>Cardiac failure 5 years</u></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>												PART	DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	1	<u>4201</u>	<u>Coronary, cerebral and generalized arteriosclerosis</u>	<u>Cardiac failure 5 years</u>	2				3			
PART	DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																								
1	<u>4201</u>	<u>Coronary, cerebral and generalized arteriosclerosis</u>	<u>Cardiac failure 5 years</u>																								
2																											
3																											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
20a. AGE AT DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>20 years</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of Item 18.) <u>Deafness 30+ years Blindness 30+ years</u>																											
21. TIME OF INJURY Month Day, Year 22. INJURY OCCURRED 23a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 23b. (City or town) (County) (State)																											
21. I certify that I (this hospital) attended the deceased from <u>January 1, 1967</u> to <u>June 6, 1967</u> , that I (we) last saw the deceased alive on <u>June 5, 1967</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.																											
22a. SIGNATURE <u>Richard N. Tillman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>June 7, 1967</u>																											
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard N. Tillman</u> 22d. ADDRESS <u>3035 St. Paul St.</u>																											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/9/1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>																											
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u> 25a. REC'D BY REG'STRAR <u>Charles Judge</u> 25b. REG'STRAR'S SIGNATURE																											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 3, MARYLAND
CERTIFICATE OF DEATH

162

27940

1. PLACE OF DEATH
 a. COUNTY Baltimore MARYLAND
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, etc.) Baltimore
 c. LENGTH OF STAY IN 1b. 6 days
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oliver Hoover Road

2. USUAL RESIDENCE Where deceased lived. If institution, residence before admission:
 a. STATE Maryland b. COUNTY Baltimore
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, etc.) Baltimore
 d. STREET ADDRESS Oliver Hoover Road
 e. RESIDENCE ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED
 Type or print First Middle Last
Thomas Scott Watts

4. DATE OF DEATH
 Month Day Year
Dec 1, 1967

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Dec. 8, 1896 9. AGE in Years (last birthday) 70 yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Co., Md. 12. CITIZEN OF WHAT COUNTRY? J.S.A.

13. FATHER'S NAME Newton Scott Watts 14. MOTHER'S MAIDEN NAME Elva Cedonia Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 212-031248 17. INFORMANT Pearl Stansbury Watts, Upperco, Md. Address Upperco, Md.

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
 PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE
 a. Metastatic Carcinomatosis
 b. Primary Sq. Cell Carcinoma of lower jaw
 c. -----
 Conditions if any which gave rise to immediate cause a. stalling the underlying cause last
 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS A POSTMORTEM PERFORMED? YES ☐ NO ☒

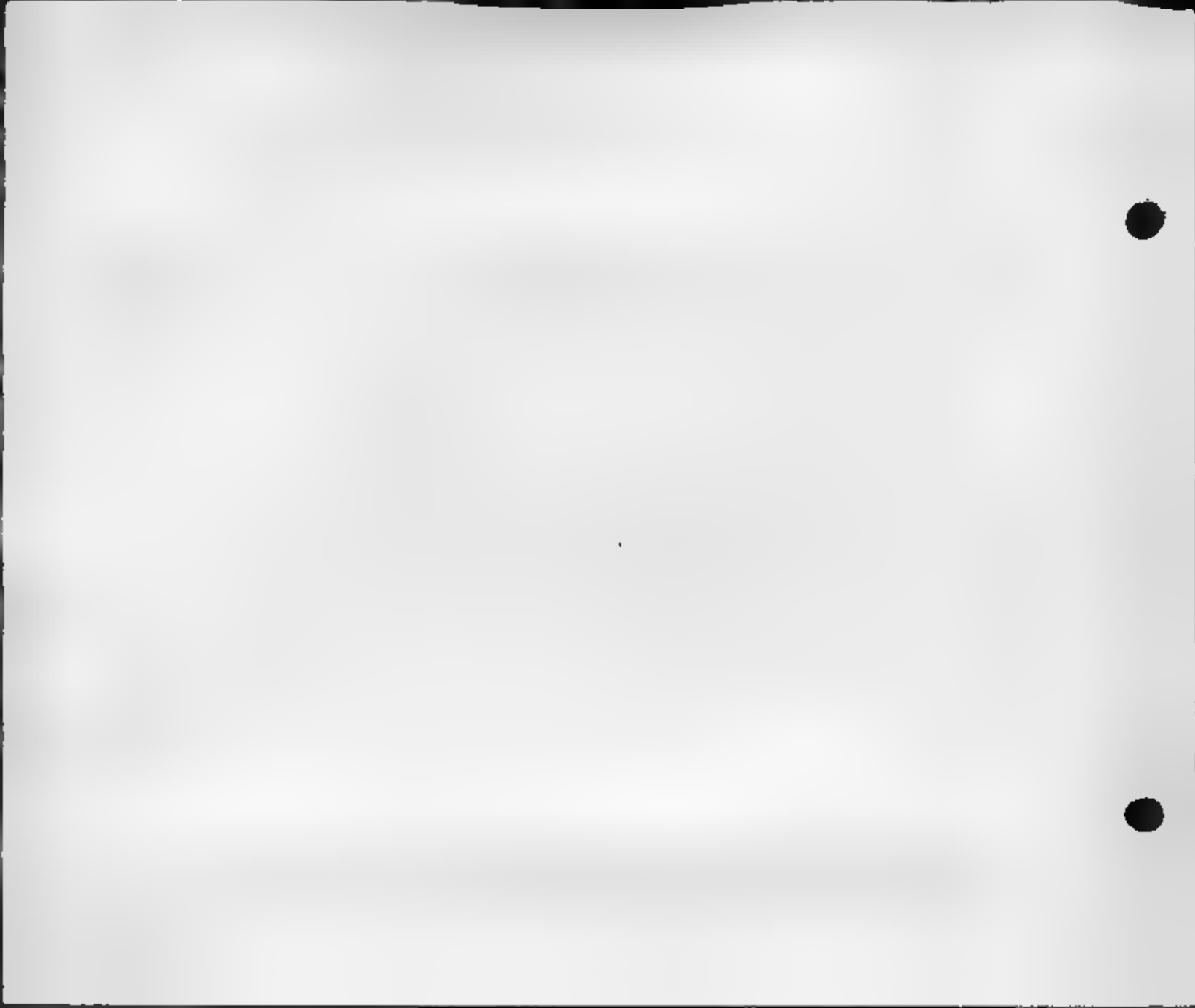
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form B)
 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 6-14-67 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) Home 20f. City or town Baltimore County Baltimore State Md.

21. I certify that this hospital attended the deceased from 10-12-66 to 6-14-67 and that death occurred at 11 AM on the cause, and on the date stated above
 22a. SIGNATURE Joseph E. Bush M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. ADDRESS 117 S. Main St. Hampstead, Md. 21074 22c. DATE 6-14-67

23a. BURIAL CREMATION. 23b. DATE THEREOF 6/17/67 23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery, Berlin, Maryland 23d. LOCATION (City, town or county) Baltimore, Maryland State Md.

24. FUNERAL DIRECTOR'S SIGNATURE H. J. Edhardt ADDRESS 1110 N. ... 25a. REC'D BY REGISTRAR Charles ... 25b. REGISTRAR'S SIGNATURE Charles ...

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person papers (pages 1 and 2) and file with the State Dept. of Health.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

37941

CERTIFICATE OF DEATH

07924

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN if outside corporate limits give RURAL and give nearest town Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY Maryland b. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Catonsville	
d. NAME OF HOSPITAL OR INSTITUTE IF NOT IN HOSPITAL give street address 1917 Rolling Glen Rd.		d. STREET ADDRESS 1917 Rolling Glen Rd.	
3 NAME OF DECEASED (Type at print) Margaret Weimer		4 DATE OF DEATH Month June Day 29 Year 1967	
5 SEX F	6 COLOR OR RACE Wh	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 10, 1891
9 Age in years last birthday 76		10 IF UNDER 1 YEAR Month 7 Day 6 Hours 0 Minutes 0	
11 BIRTH PLACE (Country & State or foreign country) Germany		12 PLACE OF BIRTH USA	
13 FATHER'S NAME Gustav Meiler		14 MOTHER (MAIDEN NAME) Josephine ----	
15 WAS DECEASED IN U.S. ARMED FORCES? (Yes only for unknown. If yes give war or dates of service) No		16 SOCIAL SECURITY NO. Ms. Hildegard Jones	
17 ADDRESS 1917 Rolling Glen Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis, cardiac, atherosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO (b) Heart failure DUE TO (c) Coronary artery disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (GIVE IN GIVEN IN PART I) None			
19a. ALTHOUGH WAS INJURED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20. TIME OF INJURY Month Day Year Hour a.m. 10 p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 20c. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. I, certify that (this hospital) attended the deceased from June 28 1967 and that death occurred at 7 A.M. from causes and on the date stated above		22. SIGNATURE Morris Steinberg, M.D.	
23a. PHYSICIAN'S NAME Type Morris Steinberg, M.D.		23b. ADDRESS 3913 Hollins Ferry Rd.	
23c. DATE OF DEATH 7/1/67		23d. NAME OF CHURCH OR CEMETERY Woodlawn Cem.	
23e. CLERK OF CHURCH OR CEMETERY Witzke F. D. - 4101 Edmondson Ave.		23f. RECORD BY REGISTRAR 6/30/67	
23g. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and sent to the burial home. Please remove a bon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event within 72 hours after death.



0.7925

4th A¹⁵ 4
25th 1 67

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN <u>Baltimore</u>		c. STATE <u>Maryland</u>		7 USUAL RESIDENCE (Where deceased lived 1 month before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>none</u>		c. LENGTH OF STAY IN "b" <u>3 1/2 days</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>none - home</u>		e. DATE OF DEATH <u>June 15, 1967</u>		f. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First <u>James</u> Middle <u>Lee</u> Last <u>Russo</u>		4 DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>		5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <u>Sept. 12, 1919</u>		9 AGE in years last birthday <u>47</u>		10 IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11 BIRTHPLACE (County & State or foreign country) <u>Ill. (Ill.)</u>		12 IF 75 OR OLDER OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>James Lee Russo</u>		14 MOTHER'S MAIDEN NAME <u>Mary Catherine Russo</u>		15 SOCIAL SECURITY NO. <u>217-14-910</u>		16 INFORMANT <u>James Lee Russo</u>		17 ADDRESS <u>1010 St. Paul Street</u>	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY <u>Brain tumor, post-operative</u>		19 IMMEDIATE CAUSE (a) <u>237x</u>		20 DUE TO (b) <u>237x</u>		21 DUE TO (c) <u>237x</u>		22 INTERVIEW BETWEEN ONSET AND DEATH <u>237x</u>	
23 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>237x</u>		24 HOW LONG UNDERLYING DISEASE OR CONDITION LASTED <u>237x</u>		25 HOW LONG UNDERLYING DISEASE OR CONDITION LASTED <u>237x</u>		26 HOW LONG UNDERLYING DISEASE OR CONDITION LASTED <u>237x</u>		27 HOW LONG UNDERLYING DISEASE OR CONDITION LASTED <u>237x</u>	
28 I certify that (1) this is a true and correct copy of the original as shown to me by the physician or medical examiner 29a SIGNATURE <u>G. Lee Russo</u>		29b PHYSICIAN'S NAME (Type) <u>G. Lee Russo, M.D.</u>		30a PLACE OF INJURY (Home, farm, factory, street, office, highway) <u>Home</u>		30b CITY OR TOWN <u>Baltimore</u>		30c COUNTY <u>Baltimore</u>	
31 I certify that (2) this is a true and correct copy of the original as shown to me by the physician or medical examiner 32a SIGNATURE <u>G. Lee Russo</u>		32b PHYSICIAN'S NAME (Type) <u>G. Lee Russo, M.D.</u>		33a PLACE OF INJURY (Home, farm, factory, street, office, highway) <u>Home</u>		33b CITY OR TOWN <u>Baltimore</u>		33c COUNTY <u>Baltimore</u>	
34 BURIAL OR CREMATION <u>Interment</u>		35 DATE THEREOF <u>June 21, 1967</u>		36 NAME OF CEMETERY OR CREMATOR <u>Greenwood Cemetery</u>		37 ADDRESS <u>1010 St. Paul Street</u>		38 CITY OR TOWN <u>Baltimore</u>	
39 FUNERAL DIRECTOR <u>James Lee Russo</u>		40 ADDRESS <u>1010 St. Paul Street</u>		41 CITY OR TOWN <u>Baltimore</u>		42 COUNTY <u>Baltimore</u>		43 STATE <u>Maryland</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the State Department of Health. Page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper and file page 4 with the funeral director.

VR 415 (4)
255a

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

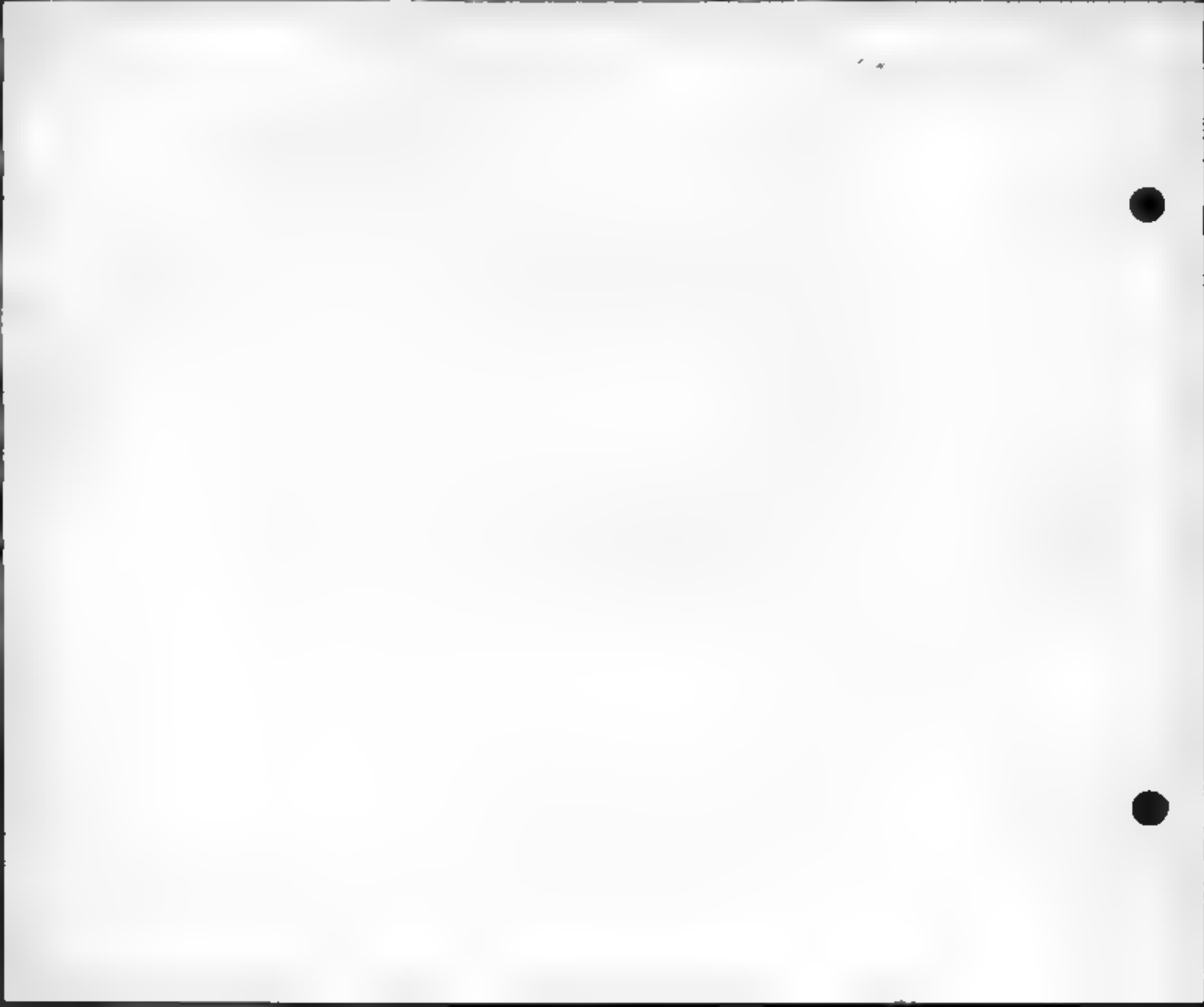
07943

CERTIFICATE OF DEATH

07328

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN PORT HOWARD c. NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN COCKEYSVILLE d. STREET ADDRESS 600 WARREN ROAD	
3. NAME OF DECEASED First Middle Last ELMER MARRYMAN WHEELER		4. DATE OF DEATH Month Day Year JUNE 17 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year 11 23 97 69
10a. USUAL OCCUPATION (If he knew it work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME JOHN THOMAS WHEELER		14. MOTHER'S MAIDEN NAME MARGARET E. FORD	
15a. SOCIAL SECURITY NO. 220 14 8837		15b. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter in layman's language the cause per se and the immediate cause) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPOVOLEMIC SHOCK DUE TO HEMORRHAGIC PANCREATITIS CONDITIONS, TONY WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STANDING THE UNDERLYING CAUSE WAS PANCREATIC ABSCESS DUE TO OBSTRUCTIVE JAUNDICE		IN HOW MANY DAYS WEEKS WEEKS WEEKS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE: CONDITION GIVEN IN PART I			
20a. INJURY (If any) Month Day Year Hour PM 20a. INJURY OR ILLNESS While <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/> Or While <input type="checkbox"/>		20b. PLACE OF INJURY OR ILLNESS Home <input type="checkbox"/> Street <input type="checkbox"/> Other <input type="checkbox"/>	
21. certify that (this hospital) attended the deceased from April 18 1966 to June 17 1967 and that death occurred on June 17 1967 at 4:55 P.M. from causes and on the date stated above			
22. SIGNATURE OF PHYSICIAN JOSE A. RAQUEL, Jr., M.D.		22. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND	
23a. BURIAL OR CREMATION BURIAL	23b. DATE THEREOF 6-21-67	23c. NAME OF CEMETERY OR CREMATORY DULANEY MEMORIAL GARDENS	
24. FUNERAL DIRECTOR R. F. Walker		24b. BY REGISTRAR 1050 York Rd. Towson, Maryland	
24c. BY REGISTRAR 1050 York Rd. Towson, Maryland		24d. BY REGISTRAR 1050 York Rd. Towson, Maryland	

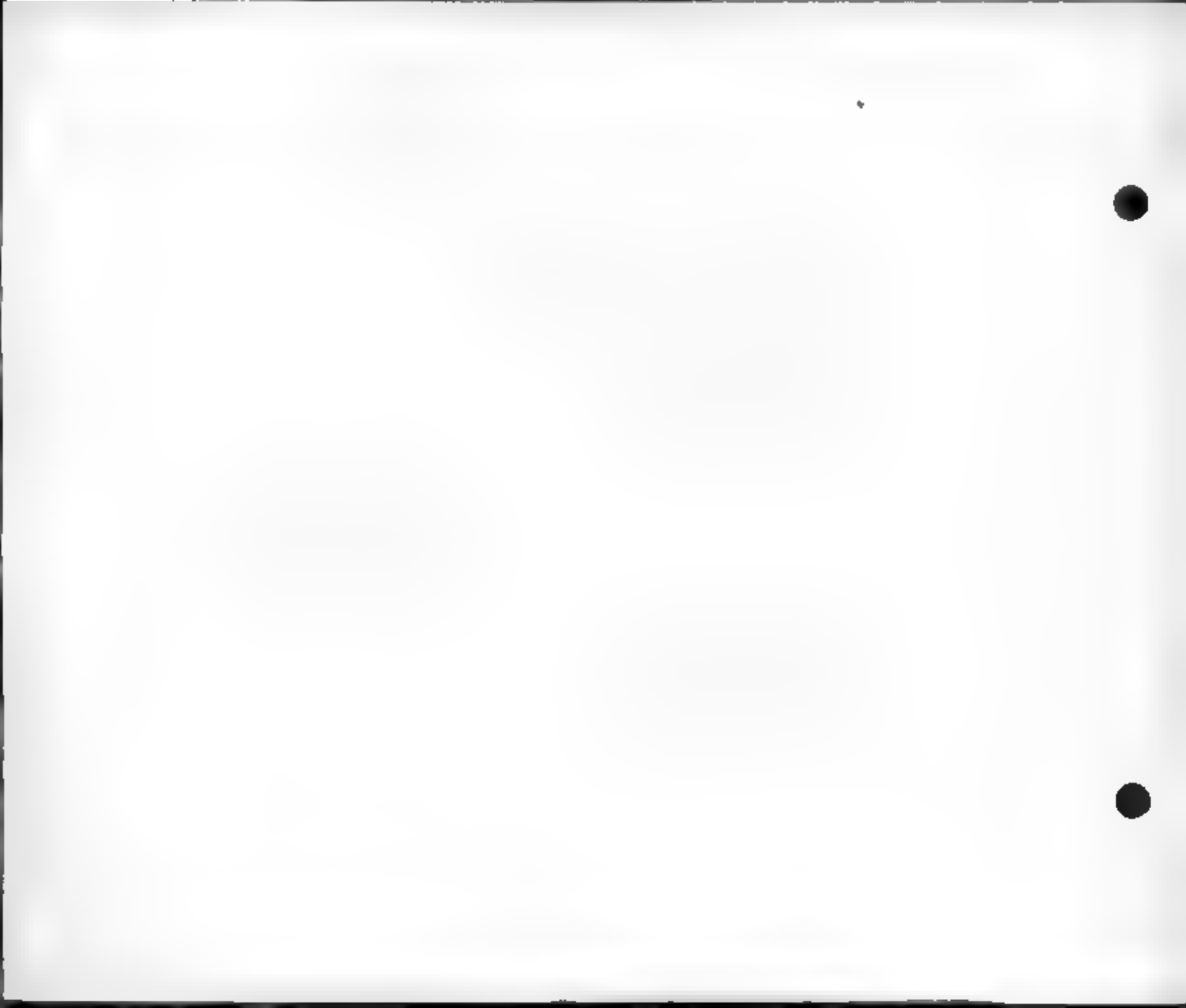
VR 415 (4)
255a



7.25

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a bar page 5. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and many events with 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon pages 7 and 8 and return them to the State Dept. of Health for burial, cremation, or removal, and many other things. Page 7 and 8 should be filed with the State Dept. of Health for burial, cremation, or removal, and many other things.

1

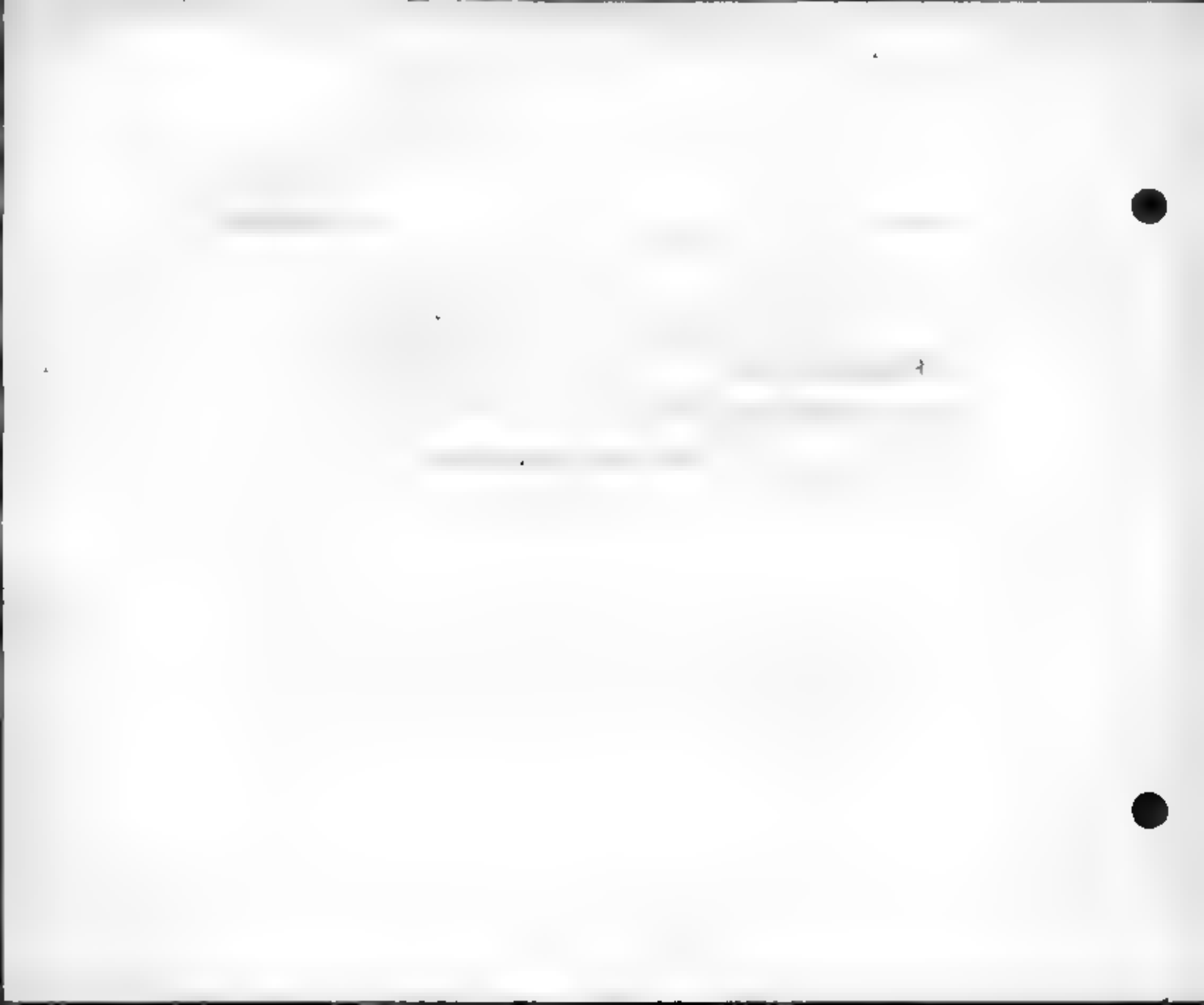
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

07945

CERTIFICATE OF DEATH

67-23

1 PLACE OF DEATH a. COUNTRY BALTO. b. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town" BALTO. c. LENGTH OF STAY IN b. 1		2 USUAL RESIDENCE (Where deceased lived if in area on Residence before admission) a. STATE Md. b. COUNTY CARROLL c. CITY OR TOWN "If outside corporate limits, write RURAL and give nearest town" HAMPSTEAD	
d. NAME OF HOSPITAL OR INSTITUTION "If not in hospital, give street address" GREATER BALTO. Med. Center		d. STREET ADDRESS 6701 N. Charles St	
3 NAME OF DECEASED Type or print First Middle Last Ethel MAY White		4 DATE OF DEATH Month Day Year 6 17 67	
5 SEX F	6 COLOR OR RACE CAU	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-9-1900
10a USUAL OCCUPATION "Kind of work done during most of working life, even if retired" HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY BALTO	9 AGE in years (last birthday) 67
3 FATHER'S NAME NORTHMORE W. DAWES		4 MOTHER'S MAIDEN NAME Ellen Rhodes	
5 WAS DECEASED EVER IN ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) no		6 SOCIAL SECURITY NO 215-07-5710	
7 INFORMANT Hospital Chart		8 ADDRESS Hospital Chart	
B CAUSE OF DEATH (Enter only one cause per line "a", "b", and "c") PART DEATH CAUSED BY IMMEDIATE CAUSE 1. ILLA Conditions "any which gave rise to immediate cause or arising life underling cause" Respiratory Failure Cerebral Metastases ? CVA Cancer of breast		INTERVAL BETWEEN ONSET AND DEATH 2	
PART II OTHER SIGNIFICANT CONDITIONS "CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE" (CONDITION GIVEN IN PART I) Arteriosclerosis		19 Was death PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
20a DECEASED UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF OTHER NOTIFY MEDICAL EXAMINER Arteriosclerosis		20b DESCRIBE HOW INJURY OCCURRED "Enter nature of injury in Part III or Part II at item 8"	
20c TIME OF INJURY Month Day Year June 17 1967	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	20f If by motor vehicle, state State
21 I certify that this hospital attended the deceased from saw the deceased alive on and the death occurred at June 17 1967		19 that we last saw the deceased alive on and the death occurred at June 17 1967	
22a SIGNATURE [Signature]		22b DATE SIGNED 6-17-67	
23a PHYSICIAN'S NAME (Type) [Signature]		22d ADDRESS [Address]	
23b BURIAL OR CREMATION (Specify) Burial		23c DATE THEREOF June 20, 1967	
23d NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23e LOCATION (City or town) (County) (State) Upperco Balto. Co. Md.	
24 FUNERAL DIRECTOR Tipton - Eline Funeral Home		25a REG. D BY REGISTRAR DA JUN 21 1967	
25b REGISTRAR'S SIGNATURE [Signature]		25c REGISTRAR'S NAME Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07946

CERTIFICATE OF DEATH

07923

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Baltimore c. RURAL or TOWN Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Baltimore Med. & Dent. Center		7 USUAL RESIDENCE (Where deceased lived if in institution) Residence before admission a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 8802 Fearnside Avenue e. IF RESIDENT ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Howard S. Whitmore		4 DATE OF DEATH Month 6 Day 23 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-12-18
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing agent		9b. KIND OF BUSINESS OR INDUSTRY American Oil Co.	9c. AGE in years last birthday 48
10 BIRTHPLACE (County & State or foreign country) Baltimore		11 IF UNDER 74 HRS. OF AGE, IF NEVER 74 HRS. OF AGE, IF WHAT OTHER REASONS Baltimore	
12 FATHER'S NAME Harry Whitmore		13 MOTHER'S MAIDEN NAME Cross BESSIE	
14 SOCIAL SECURITY NUMBER 216-01-2660		15 INFORMANT XXXXX Address:	

16 CAUSE OF DEATH (List only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 226 c. 226		17 MEDICAL CERTIFICATION PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Indicate in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERWRITING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 9 p.m. 9 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. CITY or Town (County) (State) 21. I certify that (1) the hospital attended the deceased from 6/23 1967 at 6/23 967 that (2) the deceased was seen on 6/23 967 and (3) a death occurred at 5:30 PM from causes and on the date stated above. 22a. SIGNATURE R. Breitenacker #0 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. PHYSICIAN NAME (Type) GBMC 23a. BURIAL INFORMATION (Specify) BURIAL 23b. DATE THEREOF 6-27-67 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith 23d. LOCATION (City or Town) (County) (State) Baltimore County Md. 24. FUNERAL DIRECTOR CHARLES F EVANS & SON 8802 Harford Rd 25a. REC'D BY REG. RAR JUN 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	
---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers and return page 4 to the State Dept. of Health prior to burial, cremation or removal and, whenever possible, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove, attach papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and notify event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201

27947

CERTIFICATE OF DEATH

62-31

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institutional or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If no city, appropriate limit write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside separate units, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type at print) First Middle Last <u>Ethe Marie Williams</u>		4 DATE OF DEATH Month Day Year <u>June 3 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 20 1906</u>
9 AGE in years last birthday <u>60</u>		10 UNDER 1 YEAR Months Days <u>11 11</u>	
11a. OCCUPATION (Give kind of work done during last of working life even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Secretary</u>	
12 BIRTHPLACE (County & State of foreign country) <u>Westminster, Md.</u>		13 COUNTRY OF BIRTH <u>USA</u>	
14 FATHER'S NAME <u>BAXTER BOWERS</u>		15 MOTHER'S MAIDEN NAME <u>WAGNER</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes give war or dates of service		17 SOCIAL SECURITY NO. <u>214-16-1946</u>	
18 INFORMANT <u>Patient's History</u>		Address	
19 CAUSE OF DEATH (Enter all causes per line for (a), (b) and (c)) a. IMMEDIATE CAUSE (a) <u>Peritonitis</u> b. DUE TO <u>Perforation of colon</u> c. DUE TO <u>Carcinoma of endometrium (uterine)</u>			
20 PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE (CONDITION GIVEN IN PART 19) <u>None</u>			
21a. ALCOHOL WAS INHIBITING OR CONTRIBUTING TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, NOTE BY MEDICAL EXAMINER		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 19 of Part 1 of item 18.)	
22a. TIME OF INJURY Month Day Year <u>June 3 1967</u>		22b. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input type="checkbox"/>	
23a. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>		23b. TYPE OF INJURY (Struck, fall, etc.) <u>None</u>	
24 I certify that (this hospital attended the deceased from <u>May 9 1967</u> to <u>June 3 1967</u> that we last saw the deceased alive on <u>June 3 1967</u> and that death occurred at <u>10:40 AM</u> from causes and on the date stated above			
25a. SIGNATURE <u>John E. Adams</u>		25b. DATE SIGNED <u>June 4, 1967</u>	
26 PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>		27 ADDRESS <u>670 N. Charles Street, Towson, Md.</u>	
28a. BURIAL REMOVAL (Specify)		28b. DATE THEREOF <u>June 7 1967</u>	
29 NAME OF CEMETERY <u>None</u>		30 LOCATION (City or Town, County, State) <u>Towson, Md.</u>	
31 FUNERAL DIRECTOR <u>Charles Jones</u>		32 ADDRESS <u>None</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

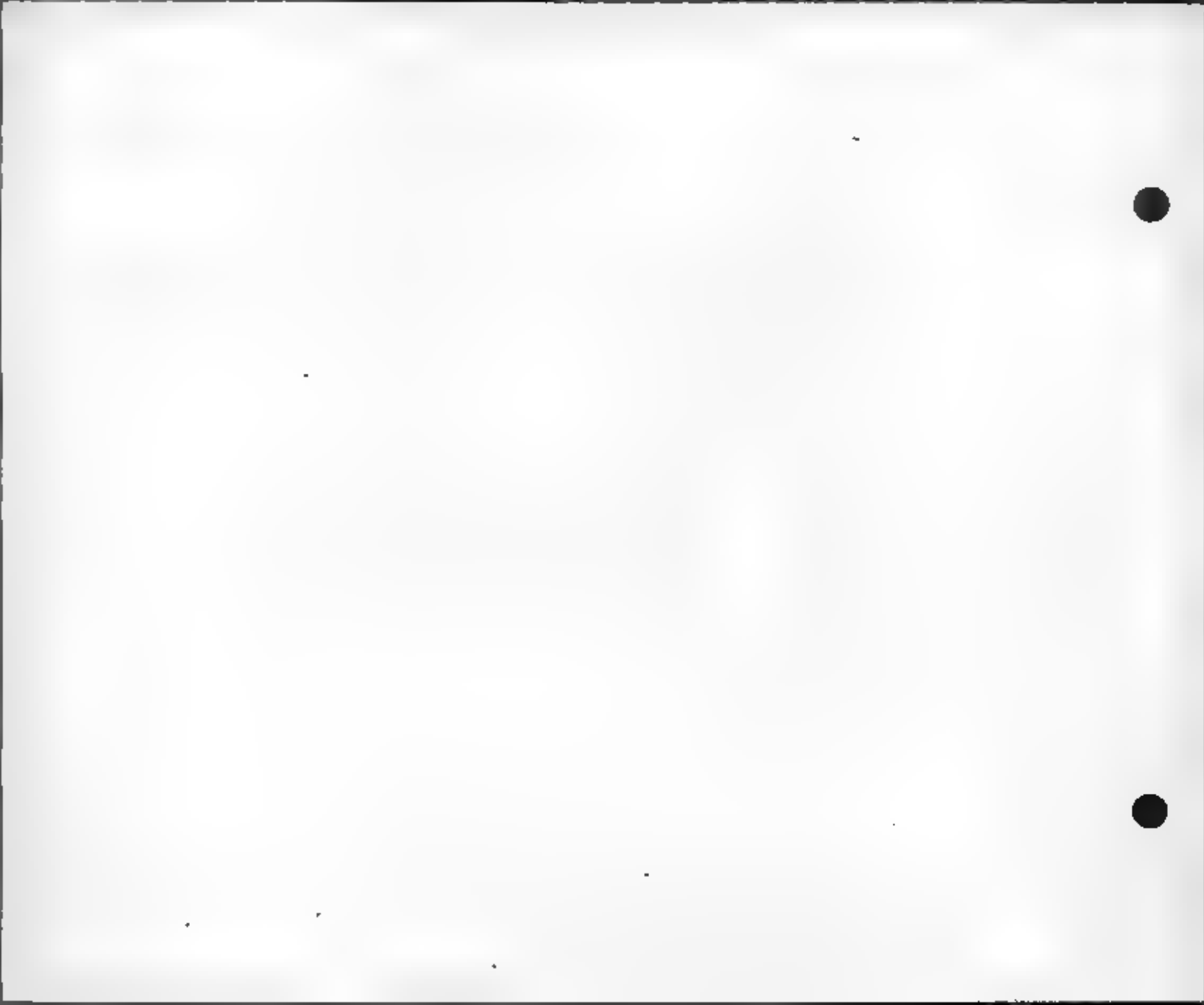
07948

07532

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Essex (21) c. LENGTH OF STAY IN IT		2 USUAL RESIDENCE (Where deceased lived immediately before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN Essex (21)	
d. NAME OF HOSPITAL, OR INSTITUTION (If not a hospital give street address) 551 Sue Grove Road		d. STREET ADDRESS 551 Sue Grove Road	
3 NAME OF DECEASED (Type in print) FREDRICK E. WILSON		4 DATE OF DEATH Month June Day 12 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE In year last birthday yrs 66
9a. OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		9b. KIND OF BUSINESS OR INDUSTRY Can Co.	9c. BIRTHPLACE (County & State or foreign country) Baltimore, Md.
10. FATHER'S NAME Benjamin Wilson		11. MOTHER'S MAIDEN NAME Christina Schrott	
12. WAS DECEASED EVER IN ARMED FORCES? No		13. SOCIAL SECURITY NO 213 01 0196A	14. INFORMANT Cassie Freda Wilson
15. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE a) CORONARY OCCLUSION b) HYPERTENSIVE CARDIO-VASCULAR DISEASE c) DISEASE Condition if any which gave rise to immediate cause or stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH SUDDEN DEATH 6 YRS	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I DIABETES MELLITUS			
20a. ACQUIDENT WAS UNDER INFLUENCE OF DRUGS OR ALCOHOL AT TIME OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY Home form, factory, street, office bldg, etc.	20f. CITY or town (County) (State)
21. I certify that (1) (this hospital) attended the deceased from JUNE 10 1967 to JUNE 12 1967 that (2) (we last saw the deceased alive on FEB 6 1967 and that death occurred at 8:55 A.M. from causes and on the date stated above			
22a. SIGNATURE <i>Joseph Miceli</i>		22b. DATE SIGNED 6/12/67	22c. PHYSICIAN'S NAME (Type) Joseph Miceli, M. D.
23a. BURIAL INFORMATION Burial (Specify) Burial		23b. DATE THEREOF 6/15/67	23c. NAME OF CEMETERY OR REIMBURSEMENT Meadowridge Memorial Fk. Baltimore, Md.
24. FUNERAL DIRECTOR Brzezinski Funeral Home		25. ADDRESS 1407 Eastern Ave.	26. REGISTERED BY REGISTRAR JUN 15 1967
27. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		28. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and may even within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove "ghost" papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and no other event may be held 72 hours after death.

VR A 5 4
20 M 68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET BALTIMORE, MARYLAND 21201

07943

CERTIFICATE OF DEATH

07533

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN If outside separate limits write RURAL or nearest town Timonium c LENGTH OF STAY IN b Yrs.		2 USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a STATE Md. b COUNTY Baltimore c CITY OR TOWN (If outside separate limits write RURAL and give nearest town) Timonium	
d NAME OF HOSPITAL OR INS. TLT DN If not in hospital give street address 2418 York Rd.		e STREET ADDRESS 2418 York Rd.	
3 NAME OF DECEASED (Print name) Minnie I Wilson SEX F 6 DIED OF RACE Cauc 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4 DATE OF DEATH June 17, 1967 5 AGE years 84 UNDER 1 YEAR Months Days Hours Min UNDER 24 HRS Months Days Hours Min	
10a ICA ID IPA IDN Give kind of work done during last working life (even if retired) Homemaker 10b KIND OF BUSINESS OR INDUSTRY		1 BIRTHPLACE (County & state or foreign country) Middletown, Balto. Md. 2 COUNTRY OF BIRTH U.S.A.	
13 FATHER'S NAME Samuel S. Tracey		14 MOTHER'S MAIDEN NAME Mary A. Grim	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 214 18 2072	
17 INFORMANT Greta Dorn, 2418 York Rd.		Address	
8 CAUSE OF DEATH (Enter only one cause per line (a) or (b) and PAR. DIA H WAS CAUSED BY IMMEDIATE CAUSE (a) 1 Cerebrovascular hemorrhage DUE TO (b) 2 arterosclerotic heart disease DUE TO 3 Atrial fibrillation		INTERVAL BETWEEN ONSET AND DEATH	
PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RECORDED IN THE PRIMARY DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a IDENTIFYING TAG WAS PLACED <input type="checkbox"/> 20b INTRINSIC CAUSE OF DEATH (If other notify MED. EXAMINER)		20c DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of Item 18.)	
20d TIME OF INJURY Month Day Year Hour a.m. p.m. 9		20e INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20f PLACE OF INJURY Home farm factory, street, office bldg., etc.		20g (City or town) (County) (State)	
21 I certify that (1) this hospital attended the deceased from Jan 1966 a June 17 1967 that (2) we last saw the deceased alive on June 12 1967 and that death occurred at 6:00 PM from causes and on the date stated above			
22a SIGNATURE Jamshid Hamed MD		22b DATE SIGNED June 17, 1967	
22c PHYSICIAN'S NAME (Type) Jamshid Hamed		22d ADDRESS 204 Joppa Rd, Towson, Md.	
23a BURIAL CREMATION REMOVAL METHOD Burial		23b DATE THROTT June 21, 67	
23c NAME OF CEMETERY OR CR MATORY Jessops, Methodist		23d LOCATION (City or town) (County) (State) Sparks, Balto. Md.	
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, , 1050 York Rd.		25a REC'D BY REGISTRAR DATE JUN 21 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

27950

CERTIFICATE OF DEATH

07.21

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. CITY <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Baltimore</u>		c. LENGTH OF STAY IN b. <u>Baltimore</u>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>3131 ...</u>		e. STREET ADDRESS <u>3131 ...</u>	
3. NAME OF DECEASED (Type or print) <u>BERNARD J. ...</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. NAME OF BUSINESS OR INDUSTRY <u>Farmer's production</u>	1. BIRTHPLACE (County & State or foreign country) <u>Baltimore</u>
3. FATHER'S NAME <u>William ...</u>		4. MOTHER'S MAIDEN NAME <u>Elizabeth Dobner</u>	
5. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; if unknown, if yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-2014</u>	7. INFORMANT <u>... ..</u>
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> CONDITIONS (if any) which gave rise to immediate cause or, stating the underlying cause (b) <u>Carcinoma of the rectum</u>		INTERVAL BETWEEN DEATH AND BIRTH <u>52 yrs</u>	
19a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE OR CONDITION GIVEN IN PART 18 <u>January, 1967 Removal of rectum & colostomy made</u>		19b. Was it a report of a physician? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. IDENTIFYING INFORMATION OR CONTRIBUTING CAUSE OF DEATH (If other, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Part II of form B) 20c. TIME OF INJURY (Month Day Year) Hour <u>...</u> AM <input type="checkbox"/> PM <input checked="" type="checkbox"/> 19 <u>67</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>...</u>		20f. City or town <u>...</u> County <u>...</u> State <u>...</u>	
21. I certify that (this hospital) attended the deceased from <u>April 20 - 1967</u> to <u>June 8 - 1967</u> that I was last saw the deceased alive on <u>June 8 - 1967</u> and that death occurred at <u>4:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>...</u>		22b. DATE SIGNED <u>6/7/67</u>	
23a. PHYSICIAN'S NAME (Type) <u>...</u>		23b. ADDRESS <u>...</u>	
23c. BURIAL REMOVAL REMOVED (Specify)	23d. DATE THEREOF <u>7/12/67</u>	23e. NAME OF EMERGENCY OR REMOVAL <u>...</u>	23f. LOCATION (City or town) (County) State <u>...</u>
24. FUNERAL DIRECTOR <u>...</u>		25a. REF'D BY REGISTRAR DATE <u>...</u> 1967	
25b. REGISTRAR'S SIGNATURE <u>...</u>		25c. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove urban page 5, pages 6 and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, and 123, and 124, and 125, and 126, and 127, and 128, and 129, and 130, and 131, and 132, and 133, and 134, and 135, and 136, and 137, and 138, and 139, and 140, and 141, and 142, and 143, and 144, and 145, and 146, and 147, and 148, and 149, and 150, and 151, and 152, and 153, and 154, and 155, and 156, and 157, and 158, and 159, and 160, and 161, and 162, and 163, and 164, and 165, and 166, and 167, and 168, and 169, and 170, and 171, and 172, and 173, and 174, and 175, and 176, and 177, and 178, and 179, and 180, and 181, and 182, and 183, and 184, and 185, and 186, and 187, and 188, and 189, and 190, and 191, and 192, and 193, and 194, and 195, and 196, and 197, and 198, and 199, and 200, and 201, and 202, and 203, and 204, and 205, and 206, and 207, and 208, and 209, and 210, and 211, and 212, and 213, and 214, and 215, and 216, and 217, and 218, and 219, and 220, and 221, and 222, and 223, and 224, and 225, and 226, and 227, and 228, and 229, and 230, and 231, and 232, and 233, and 234, and 235, and 236, and 237, and 238, and 239, and 240, and 241, and 242, and 243, and 244, and 245, and 246, and 247, and 248, and 249, and 250, and 251, and 252, and 253, and 254, and 255, and 256, and 257, and 258, and 259, and 260, and 261, and 262, and 263, and 264, and 265, and 266, and 267, and 268, and 269, and 270, and 271, and 272, and 273, and 274, and 275, and 276, and 277, and 278, and 279, and 280, and 281, and 282, and 283, and 284, and 285, and 286, and 287, and 288, and 289, and 290, and 291, and 292, and 293, and 294, and 295, and 296, and 297, and 298, and 299, and 300, and 301, and 302, and 303, and 304, and 305, and 306, and 307, and 308, and 309, and 310, and 311, and 312, and 313, and 314, and 315, and 316, and 317, and 318, and 319, and 320, and 321, and 322, and 323, and 324, and 325, and 326, and 327, and 328, and 329, and 330, and 331, and 332, and 333, and 334, and 335, and 336, and 337, and 338, and 339, and 340, and 341, and 342, and 343, and 344, and 345, and 346, and 347, and 348, and 349, and 350, and 351, and 352, and 353, and 354, and 355, and 356, and 357, and 358, and 359, and 360, and 361, and 362, and 363, and 364, and 365, and 366, and 367, and 368, and 369, and 370, and 371, and 372, and 373, and 374, and 375, and 376, and 377, and 378, and 379, and 380, and 381, and 382, and 383, and 384, and 385, and 386, and 387, and 388, and 389, and 390, and 391, and 392, and 393, and 394, and 395, and 396, and 397, and 398, and 399, and 400, and 401, and 402, and 403, and 404, and 405, and 406, and 407, and 408, and 409, and 410, and 411, and 412, and 413, and 414, and 415, and 416, and 417, and 418, and 419, and 420, and 421, and 422, and 423, and 424, and 425, and 426, and 427, and 428, and 429, and 430, and 431, and 432, and 433, and 434, and 435, and 436, and 437, and 438, and 439, and 440, and 441, and 442, and 443, and 444, and 445, and 446, and 447, and 448, and 449, and 450, and 451, and 452, and 453, and 454, and 455, and 456, and 457, and 458, and 459, and 460, and 461, and 462, and 463, and 464, and 465, and 466, and 467, and 468, and 469, and 470, and 471, and 472, and 473, and 474, and 475, and 476, and 477, and 478, and 479, and 480, and 481, and 482, and 483, and 484, and 485, and 486, and 487, and 488, and 489, and 490, and 491, and 492, and 493, and 494, and 495, and 496, and 497, and 498, and 499, and 500, and 501, and 502, and 503, and 504, and 505, and 506, and 507, and 508, and 509, and 510, and 511, and 512, and 513, and 514, and 515, and 516, and 517, and 518, and 519, and 520, and 521, and 522, and 523, and 524, and 525, and 526, and 527, and 528, and 529, and 530, and 531, and 532, and 533, and 534, and 535, and 536, and 537, and 538, and 539, and 540, and 541, and 542, and 543, and 544, and 545, and 546, and 547, and 548, and 549, and 550, and 551, and 552, and 553, and 554, and 555, and 556, and 557, and 558, and 559, and 560, and 561, and 562, and 563, and 564, and 565, and 566, and 567, and 568, and 569, and 570, and 571, and 572, and 573, and 574, and 575, and 576, and 577, and 578, and 579, and 580, and 581, and 582, and 583, and 584, and 585, and 586, and 587, and 588, and 589, and 590, and 591, and 592, and 593, and 594, and 595, and 596, and 597, and 598, and 599, and 600, and 601, and 602, and 603, and 604, and 605, and 606, and 607, and 608, and 609, and 610, and 611, and 612, and 613, and 614, and 615, and 616, and 617, and 618, and 619, and 620, and 621, and 622, and 623, and 624, and 625, and 626, and 627, and 628, and 629, and 630, and 631, and 632, and 633, and 634, and 635, and 636, and 637, and 638, and 639, and 640, and 641, and 642, and 643, and 644, and 645, and 646, and 647, and 648, and 649, and 650, and 651, and 652, and 653, and 654, and 655, and 656, and 657, and 658, and 659, and 660, and 661, and 662, and 663, and 664, and 665, and 666, and 667, and 668, and 669, and 670, and 671, and 672, and 673, and 674, and 675, and 676, and 677, and 678, and 679, and 680, and 681, and 682, and 683, and 684, and 685, and 686, and 687, and 688, and 689, and 690, and 691, and 692, and 693, and 694, and 695, and 696, and 697, and 698, and 699, and 700, and 701, and 702, and 703, and 704, and 705, and 706, and 707, and 708, and 709, and 710, and 711, and 712, and 713, and 714, and 715, and 716, and 717, and 718, and 719, and 720, and 721, and 722, and 723, and 724, and 725, and 726, and 727, and 728, and 729, and 730, and 731, and 732, and 733, and 734, and 735, and 736, and 737, and 738, and 739, and 740, and 741, and 742, and 743, and 744, and 745, and 746, and 747, and 748, and 749, and 750, and 751, and 752, and 753, and 754, and 755, and 756, and 757, and 758, and 759, and 760, and 761, and 762, and 763, and 764, and 765, and 766, and 767, and 768, and 769, and 770, and 771, and 772, and 773, and 774, and 775, and 776, and 777, and 778, and 779, and 780, and 781, and 782, and 783, and 784, and 785, and 786, and 787, and 788, and 789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.



FOR STATE
HEALTH DEPT

07951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07335

[illegible]

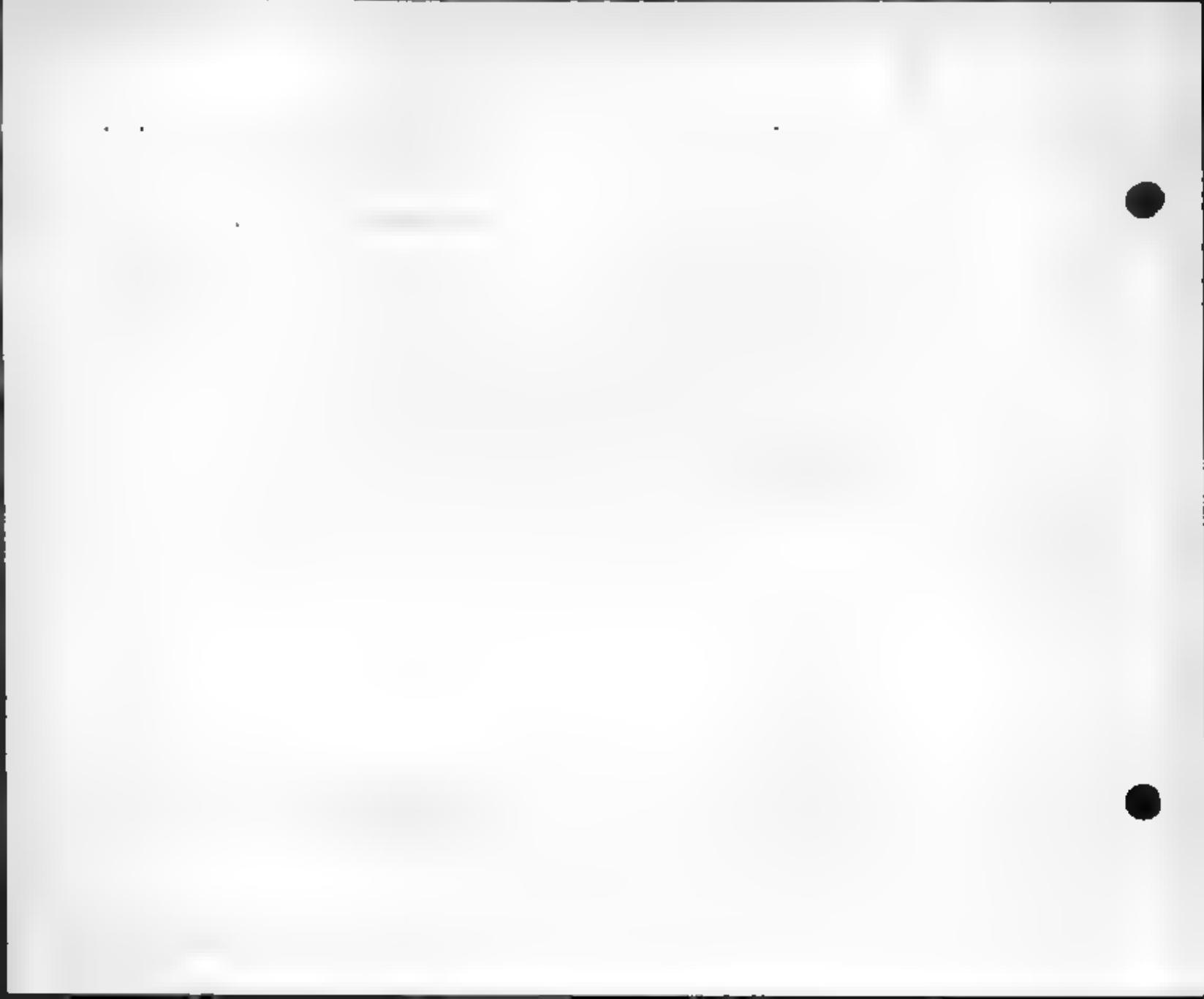
TO DEPUTY MEDICAL EXAMINER

TO FUNERAL DIRECTOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town.) <u>Baltimore</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address.) <u>Foxleight Nursing Home</u>				2 USUAL RESIDENCE Where deceased lived, if institution; Real before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				3 AGE (In years, last birthday) <u>75</u> yrs			
4 SEX <u>Male</u> 5 COLOR OR RACE <u>White</u> 6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>				7 DATE OF BIRTH <u>June 13, 1891</u> 8 DATE OF DEATH <u>June 8, 1967</u> 9 MONTH <u>6</u> DAY <u>8</u> YEAR <u>1967</u>				10 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> 12 INDUSTRY <u>Edgewood Arsenal</u> 13 BIRTHPLACE (County & State, or foreign country) <u>Germany</u> 14 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				15 FATHER'S NAME <u>unknown</u> 16 MOTHER'S MAIDEN NAME <u>unknown</u>				17 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes</u> 18 SOCIAL SECURITY NO. <u>218-18-6691</u> 19 INFORMANT <u>Mrs. Dorothy Oliff - 3509 Hillmanere Rd. (7)</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> (b) <u>Due to</u> (c) <u>Due to</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a.											
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) <input type="checkbox"/> 19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 19c. TIME OF INJURY Month, Day, Year <u>1967</u> 19d. INJURY OCCURRED <u>at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/> 19e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 19f. (City or town) (County) (State)											
20 I certify that (1) this hospital attended the deceased from <u>5/2</u> 19 <u>67</u> to <u>6/5</u> 19 <u>67</u> that (2) we last saw the deceased alive on <u>6/4</u> 19 <u>67</u> and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above. 21a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 21b. PHYSICIAN'S NAME (Type) <u>[Name]</u> 21c. ADDRESS <u>[Address]</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>June 8, 1967</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> 22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> 23 FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hwy., Baltimore</u> 24 REC'D BY REGISTRAR <u>[Signature]</u> 25 REGISTRAR'S SIGNATURE <u>[Signature]</u> 26 DATE <u>JUN 9 1967</u>											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

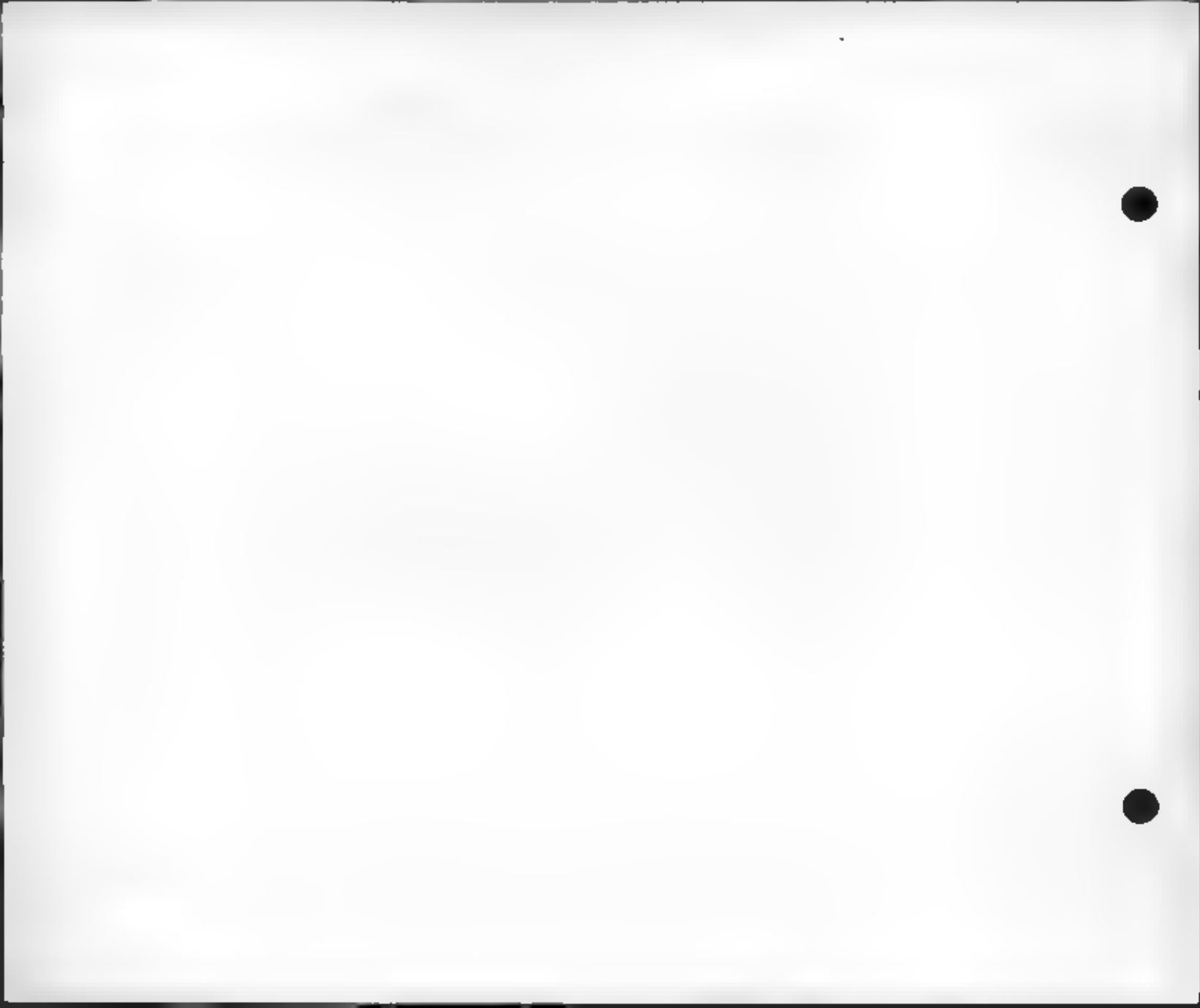
37953

CERTIFICATE OF DEATH

1733

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR A certificate note has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached to use as the burial permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health. A death certificate should be filed with the State Dept. of Health.

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe c STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived in institution Res. derive before admission) a STATE Maryland b COUNTY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe d STREET ADDRESS 1915 Woodside Ave. e IS RESIDENCE IN A - ARMED YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED First Frank Middle A. Last Wood d DATE OF DEATH Month June Day 5 Year 1967		4 SEX Male 5 COLOR OF RACE White 6 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7 DATE OF BIRTH 10/27/96 8 AGE in years (sign birthday) 70 9 IF UNDER 1 YEAR Month 1 Days 5 10 IF UNDER 24 HRS. Hours 1 Min. 3	
11 Co. U.S. or F. CITIZENSHIP (Give kind of work done during this working life, ever if retired) Installation (retired) 12 KIND OF BUSINESS OR INDUSTRY F. A. Davis 13 BIRTHPLACE (County & state or foreign country) Maryland 14 ZIP OF WHAT COUNTRY USA		15 FATHER'S NAME William Wood 16 MOTHER'S MAIDEN NAME Mary E. Eyer	
17 Was DECEASED EVER IN U.S. ARMED SERVICE? (Yes, no, or unknown, all yes give year or dates of service) Yes WWI 18 SOCIAL SECURITY NO. 213-03-7980 19 INFORMANT Mrs. Leonora Wood Address: 1915 Woodside Ave.		20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarct (b) Coronary Artery Disease (c) 193	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE (GIVEN IN PART I) 21a Age, SEX, RACE, BIRTH DATE, UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b SEX, RACE, BIRTH DATE, MONTH, DAY, YEAR 21c INJURY DESCRIBED (If injury in Part I or Part II of item B.) 21d PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21e CITY OR TOWN 21f STATE		22 I certify that (1) this hospital attended the deceased from June 5 1967 to June 5 1967 that I saw the deceased alive on 6/3 1967 and that death occurred at 9 P.M. from causes and on the date stated above. 22a SIGNATURE Morris B. Schreiber M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b ADDRESS 1519 W. Lombard St.	
23a SURVIVOR'S REMOVAL (Specify) Burial 23b DATE OF REMOVAL 6/8/67 23c NAME OF MATTRESS OR REMOVAL Parkwood Cemetery ADDRESS 21229 23d CITY OR TOWN Baltimore 23e STATE Md.		24 FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 25a REL'D BY REGISTRAR JUN 8 1967 25b REGISTRAR SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

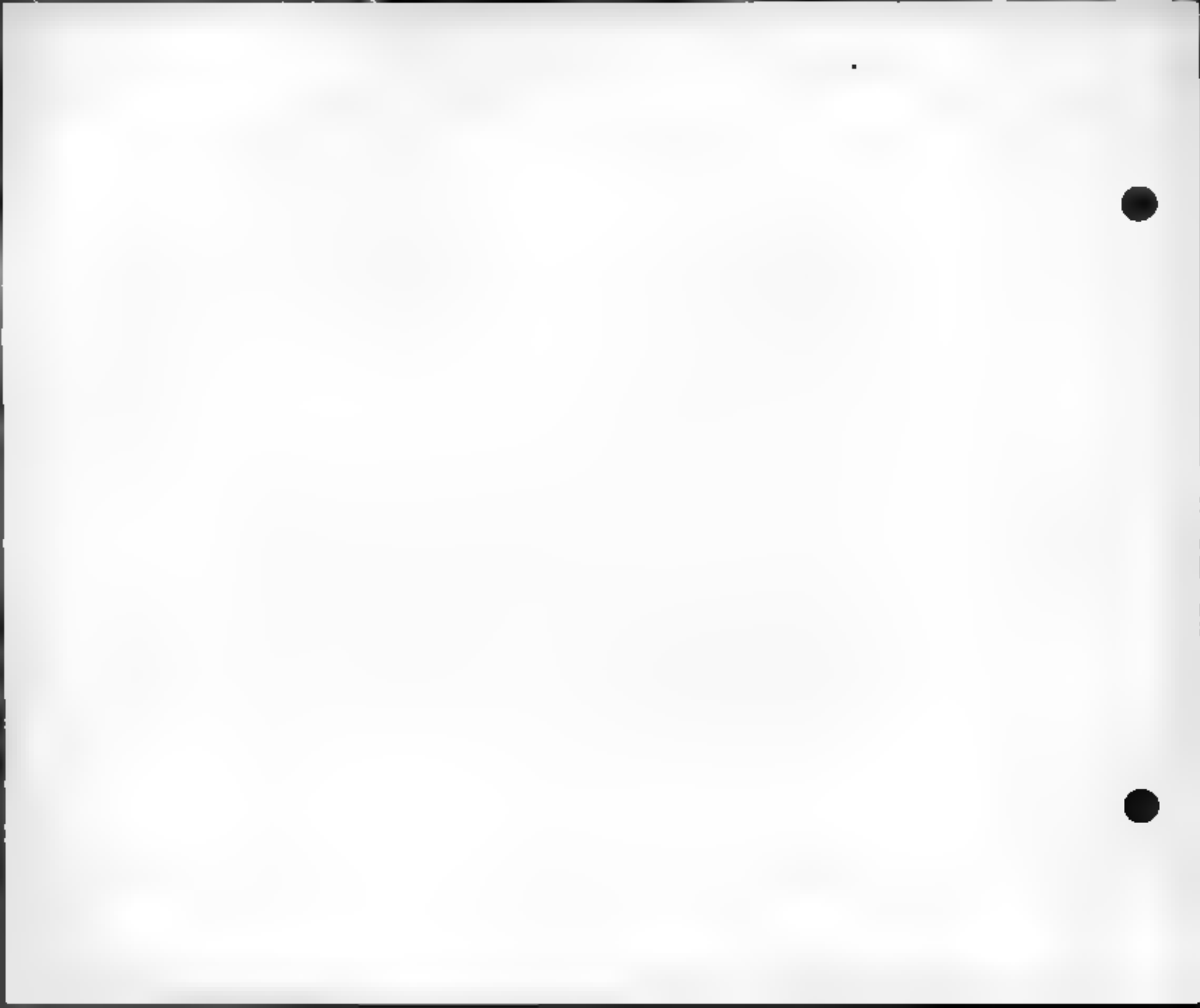
CERTIFICATE OF DEATH

07954

07933

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		2 USUAL RESIDENCE (Where deceased lived at institution. For death in care admission, b COUNTY <u>Maryland</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>163 Oaklee Village</u>		e TRAIL ADDRESS <u>163 Oaklee Village</u>	
3 NAME OF DECEASED a First <u>George</u> b Middle <u>J.</u> c Last <u>Yonkunas</u>		4 DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-13-1902</u>
9 AGED in years <u>65</u> 101st birthday <u>65</u> yrs		11 IF UNDER 1 YEAR Months <u> </u> Day <u> </u> Hour <u> </u> Min <u> </u>	
12 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>		13 BIRTHPLACE (County & state or foreign country) <u>Lithuania</u>	
14 FATHER'S NAME <u>John Jankunas</u>		15 MOTHER MAIDEN NAME <u>Aneli Kacanauskas</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		17 SOCIAL SECURITY NO. <u>214-03-4891</u>	
18 CAUSE OF DEATH (Enter only one cause per line to total 10 lines) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260x</u> DUE TO <u>Generalized Atherosclerosis</u> conditions if any, which gave rise to immediate cause of death, stating the underlying cause last <u>Heart Disease</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (b) <u> </u>		19 INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH FATHER NOTIFY MEDICAL EXAMINER		21 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 of item 8)	
22 TIME OF INJURY Month Day Year Hour <u> </u> am <u> </u> pm <u> </u> 19 <u> </u>		23 INJURY NOT IRRADIATED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24 PART OF INJURY (If in factory, street, office bldg., etc.)		25 IN <u> </u> town <u> </u> county <u> </u> State <u> </u>	
26 certify that this hospital attended the deceased from <u>May 19 1967</u> to <u>June 2 1967</u> and that the deceased died on <u>June 2 1967</u> and that death occurred at <u>324</u> from causes and on the date stated above			
27 SIGNATURE <u>Dr. John Healy</u> M.D.		28 ADDRESS <u>1311 Francis Avenue</u>	
29 BIRTH INFORMATION, REMOVAL, specify <u>Burial</u>		30 DATE THEREOF <u>6/5/67</u>	
31 NAME OF EMPLOYER OR RELATIVE <u>St. Stanislaus Cemetery</u>		32 LOCATION in <u>Baltimore</u> County <u>Md</u>	
33 FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		34 ADDRESS <u>4107 Wilkens Ave.</u>	
35 RECEIVED BY REGISTRAR <u>June 5 1967</u>		36 REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is hereby filled in by the funeral director. Page 3 may be retained by the funeral director. Page 4 may be retained by the funeral director. Page 5 may be retained by the funeral director. Page 6 may be retained by the funeral director. Page 7 may be retained by the funeral director. Page 8 may be retained by the funeral director. Page 9 may be retained by the funeral director. Page 10 may be retained by the funeral director. Page 11 may be retained by the funeral director. Page 12 may be retained by the funeral director. Page 13 may be retained by the funeral director. Page 14 may be retained by the funeral director. Page 15 may be retained by the funeral director. Page 16 may be retained by the funeral director. Page 17 may be retained by the funeral director. Page 18 may be retained by the funeral director. Page 19 may be retained by the funeral director. Page 20 may be retained by the funeral director. Page 21 may be retained by the funeral director. Page 22 may be retained by the funeral director. Page 23 may be retained by the funeral director. Page 24 may be retained by the funeral director. Page 25 may be retained by the funeral director. Page 26 may be retained by the funeral director. Page 27 may be retained by the funeral director. Page 28 may be retained by the funeral director. Page 29 may be retained by the funeral director. Page 30 may be retained by the funeral director. Page 31 may be retained by the funeral director. Page 32 may be retained by the funeral director. Page 33 may be retained by the funeral director. Page 34 may be retained by the funeral director. Page 35 may be retained by the funeral director. Page 36 may be retained by the funeral director. Page 37 may be retained by the funeral director. Page 38 may be retained by the funeral director. Page 39 may be retained by the funeral director. Page 40 may be retained by the funeral director. Page 41 may be retained by the funeral director. Page 42 may be retained by the funeral director. Page 43 may be retained by the funeral director. Page 44 may be retained by the funeral director. Page 45 may be retained by the funeral director. Page 46 may be retained by the funeral director. Page 47 may be retained by the funeral director. Page 48 may be retained by the funeral director. Page 49 may be retained by the funeral director. Page 50 may be retained by the funeral director. Page 51 may be retained by the funeral director. Page 52 may be retained by the funeral director. Page 53 may be retained by the funeral director. Page 54 may be retained by the funeral director. Page 55 may be retained by the funeral director. Page 56 may be retained by the funeral director. Page 57 may be retained by the funeral director. Page 58 may be retained by the funeral director. Page 59 may be retained by the funeral director. Page 60 may be retained by the funeral director. Page 61 may be retained by the funeral director. Page 62 may be retained by the funeral director. Page 63 may be retained by the funeral director. Page 64 may be retained by the funeral director. Page 65 may be retained by the funeral director. Page 66 may be retained by the funeral director. Page 67 may be retained by the funeral director. Page 68 may be retained by the funeral director. Page 69 may be retained by the funeral director. Page 70 may be retained by the funeral director. Page 71 may be retained by the funeral director. Page 72 may be retained by the funeral director. Page 73 may be retained by the funeral director. Page 74 may be retained by the funeral director. Page 75 may be retained by the funeral director. Page 76 may be retained by the funeral director. Page 77 may be retained by the funeral director. Page 78 may be retained by the funeral director. Page 79 may be retained by the funeral director. Page 80 may be retained by the funeral director. Page 81 may be retained by the funeral director. Page 82 may be retained by the funeral director. Page 83 may be retained by the funeral director. Page 84 may be retained by the funeral director. Page 85 may be retained by the funeral director. Page 86 may be retained by the funeral director. Page 87 may be retained by the funeral director. Page 88 may be retained by the funeral director. Page 89 may be retained by the funeral director. Page 90 may be retained by the funeral director. Page 91 may be retained by the funeral director. Page 92 may be retained by the funeral director. Page 93 may be retained by the funeral director. Page 94 may be retained by the funeral director. Page 95 may be retained by the funeral director. Page 96 may be retained by the funeral director. Page 97 may be retained by the funeral director. Page 98 may be retained by the funeral director. Page 99 may be retained by the funeral director. Page 100 may be retained by the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07955

CERTIFICATE OF DEATH

07933

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Baltimore c. LENGTH OF STAY IN 1b Rural--Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
3. NAME OF DECEASED (Type or print) First VICTOR Middle ZAPPACOSTA Last ZAPPACOSTA		4. DATE OF DEATH Month June Day 6 Year 19 67.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1893.
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donato Zappacosta		14. MOTHER'S MAIDEN NAME Franchisea Trotta	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-9976	
17. INFORMANT Mrs. Giacomina Zappacosta		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 59 to 6-6 , 19 67 , that (I) (we) last saw the deceased alive on 3-8 , 19 67 , and that death occurred at 6-7-67 M, from causes and on the date stated above.			
22a. SIGNATURE Lawrence M. Jerca		22b. DATE SIGNED 6-7-67	
22c. PHYSICIAN'S NAME (Type) LAWRENCE M. JERCA		22d. ADDRESS 11 E. CHASE ST	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/10/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR JUN 8 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07956

CERTIFICATE OF DEATH

07940

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MD.</u> c. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 6, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>217 Church Lane, Pikesville 6, MD.</u>		d. STREET ADDRESS <u>217 Church Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Zimmer</u>		4. DATE OF DEATH Month Day Year <u>June 16, 1967</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Zimmer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Peck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-5367</u>	
17. INFORMANT <u>Mr. George Zimmer, 217 Church Lane, Pikesville</u>		Address <u>21208, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis of hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>June 1967</u> that (I) (we) last saw the deceased alive on <u>June 16, 1967</u> , and that death occurred at <u>6:12</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. E. Martin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		22d. ADDRESS <u>Pikesville 6, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>June 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Pikesville 6, MD.</u>
24. FUNERAL DIRECTOR <u>Frank H. Nard</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 26 1967</u>	

